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**Feeding pre-school children:
Negotiating good motherhood through
food**

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requirements for the degree of
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Declaration

This thesis is my own original work and it has not been submitted for a degree at any other university.

Abstract

Food retains a central importance in family life, which extends beyond its nutritional necessity. Through in-depth interviews with 39 mothers of pre-school children, this study focuses on how mothers negotiate the complex and competing priorities of feeding their children. Mothers are expected to feed their children, according to expert definitions of appropriate nutrition, whilst taking account of individual food preferences and structural constraints. The ways that feeding children intersects with the construction of 'good' mother or how mothers negotiate external information and advice on feeding their children has not been the focus of much research. This research considers these issues at a time when government policy remains focused on health, lifestyles and obesity. This study shows that mothers feel the responsibility of motherhood strongly whilst accepting their accountability. It also shows that feeding children is one of the main concerns of mothers of young children and one that occupies a great deal of time. By talking to mothers of different ages and living in different social circumstances, this study shows that all mothers accept the links between food and health and all take account of these links as they look to their children's future health. All mothers seek external sources of information and advice but sources differ with mothers' age and social class. Expertise is found not to be the preserve of those with formal qualifications as mothers talked of how expertise is negotiated. Mothers therefore work hard to negotiate their own versions of good motherhood through their food decision-making. By focussing on the aspects of feeding children that are considered the most important at any given time, mothers are able to negotiate their own sense of good motherhood.

Introduction

You know what, if you've got a kid with a good diet that's happy and healthy, to me that's everything. (Emily, age 26, 2 children)

Food retains a central role in family life through both its necessity in the functioning of bodies, healthy or otherwise, and in its symbolic role as a way to construct family. Despite its centrality, feeding children is, of course, only one of the many tasks that mothers undertake. Juggling the many priorities that mothers face daily requires negotiation not only between priorities but also within tasks such as food provisioning. Compromises must be negotiated, taking account of myriad factors including individual taste preferences, time, budget, ideal diet composition, capabilities and access to food. Women remain largely responsible for this family food work, particularly taking on planning and decision making roles, even when they have partners who are involved in some food preparation work (Stapleton and Keenan, 2009; James et al., 2009; Wilk, 2010). Motherhood further changes expectations as Stapleton and Keenan (2009: 48) found, food was 'perceived as part of the maternal role', putting the onus firmly on women even in heterosexual couples where previously food work had been shared. Although the roles and responsibilities of motherhood are socially constructed and change over time (Smart, 1996), mothers feel and take on the responsibility for feeding their family. The negotiation of motherhood and, in particular, negotiating being a 'good' mother is an ongoing process and feeding children is one way in which mothers can represent themselves as 'good' mothers. Furthermore, it is also one way in which they can be judged both externally, as young children are monitored on growth charts and feeding children in the many public spaces in which food is consumed is scrutinised, and internally as

mothers deal with the realities of feeding children, which may not match ideals of healthy eating.

The construction of ‘good’ mothering in the current neoliberal climate is founded on the intensive motherhood ideal, coined in the 1990s by Sharon Hays (1996) to describe an ideology whereby the child’s needs were put above those of its mother. Intensive mothers were further required to commit considerable time and resources to their child (Hays, 1996). Vincent (2010) argues that this notion of intensive mothering has become symbolic of the norm, or at least the aspirational norm, in current society with mothers using such norms to claim a moral self as mother (May, 2008; Vincent, 2010). This construction of intensive child rearing, therefore, puts the burden of responsibility directly on mothers (Shirani et al., 2012). This body of research constructs good mothers as those with resources, partners, and middle class norms, simultaneously constructing those without such resources, especially single parents, as inferior (Leigh et al., 2012. Vincent, 2010; Vincent and Ball, 2007). Such expectations of motherhood give rise to comparisons between mothers, which can lead to feelings of anxiety, guilt or failure when mothers feel they are not performing well. In the face of such high standards which some mothers acknowledge they are not going to be able to achieve, some construct an alternative, that of being a ‘good enough’ parent (Bloomfield, 2005). Whilst this notion of ‘good enough’ parent was applied to general parenting issues, it is one that can be considered in relation to feeding children.

Feeding children is only one aspect of mothering, but it is one that occupies a great deal of mothers’ time; food work includes planning, shopping, preparing, eating and clearing away of meals, multiple times a day. Decisions on what to prepare at any given food event, in any household are complex and have been the

focus of research in many disciplines including, dietetics, public health, psychology, health promotion and sociology. Studies emphasise knowledge (what should be fed to children) and behaviour (what is actually being fed to children) rather than looking at how mothers experience feeding children. Research covers factors that influence when mothers wean¹ their babies (Alder et al., 2004; Anderson et al., 2001; Tatone-Tokuda et al., 2009), mothers' knowledge about weaning (Hobbie et al., 2000; McLeod et al., 2011; Williams et al., 2012), and what influences mothers' actions (May et al., 2007; Skinner et al., 2002). The pre-school period has also come under a great deal of scrutiny with research focussing on what pre-school children eat, particularly in relation to their consumption of adequate fruits and vegetables (Skinner et al., 2002; Hudson et al., 2005; Wardle et al., 2005). Mothers' knowledge, at every stage of feeding their children, is assessed by these studies, but less is known about how they understand information on feeding their children and what they do with information that they receive. Furthermore, more attention is paid to the process of moving children onto mixed feeding and assessing their diet once they are past the weaning stage. Fewer studies focus on how mothers think about food, as everyday practice, once the work of getting their children on a mixed diet has been achieved, or how they negotiate food provisioning as part of everyday life, despite this work being routine, social and relational (Abbots and Lavis, 2013). Furthermore, looking at the way that feeding children intersects with the construction of 'good' mother has not been the focus of much research.

All of the assumptions above are predicated on the notion that food consumption is largely a matter of choice, based on knowledge. If individuals are

¹ Weaning means gradually introducing a range of solid foods to your baby, until they are eating the same food as the rest of your family.
<http://www.nhsdirect.wales.nhs.uk/encyclopaedia/b/article/babies,weaning/> {accessed 14/03/14}

given the correct information about the links between food and health then rational individuals will make the right (healthy) choices. Notions of expertise are also crucial to this agenda as experts define what is the 'right' choice in relation to food, along with normality in relation to child development and behaviour, thus allowing parents to position themselves as 'good' parents (Coveney, 2008). Yet understanding who mothers regard as experts in different situations and how these experts are engaged with, is less well understood. Freedom to choose, in accordance with expert advice, is embedded in neoliberal policymaking, along with individual responsibility to make these 'right' choices (Brooks et al., 2013). Brooks et al. (2013) question the effectiveness of the choice agenda and its reliance on behaviour change through their analysis of the way it has been written into UK food policy over the past 30 years with little effect. Yet the choice agenda remains central to public policy, as embodied in the current public health policy document *Healthy Lives, Healthy People* (DOH, 2010b), which sets out the ways in which health improvement can be achieved. Women are regarded as key targets before, during and after pregnancy as they are considered fundamental in establishing healthy foundations for children, and therefore, future generations. To help deliver the targets of the health policy the government devised a three year marketing strategy which focuses on 'lifestyles', with suggested action to improve knowledge about what constitutes a healthy 'lifestyle' (DOH, 2011). These strategies, which target early years, look to the actions of parents, emphasise the need for changes, to promote better health both now and in the future with a particular focus on reduction in weight-related ill health. Although ostensibly targeting parents, such policies really focus on mothers who are entreated to take on the burden of responsibility. The increasing focus on mothers' responsibility in government policy is clearly demonstrated by Grover and Mason's

(2013) analysis of the current coalition government's early years strategy to reduce child poverty and increase social mobility. Grover and Mason (2013) found that the document mentioned mothers seven times more frequently than fathers and constructed an idealised notion of mothers and motherhood. In policy terms, the current coalition government regards mothers as the key players in changing the diets of children and thereby contributing to longer-term population health improvements. Although more recent policies have recognised structural issues to some extent through their recognition that consumers may need 'help' in making the 'right' choices, claiming that help is readily available has left those failing to make the 'right' choices being regarded as problematic or deviant (Brooks et al., 2013). Cohn (2013) further argues that conceiving of diet as a health behaviour allows individuals to be conceptualised as both in control of, and responsible for, their actions, further dismissing the importance of social and structural circumstances. Positioning health as the primary focus of dietary choice, he argues, reduces the practice of eating to the consumption of particular foods rather than a practice with cultural meaning (Cohn, 2013).

This study considers how mothers of pre-school children negotiate these complex and competing priorities of feeding their children, according to expert definitions of appropriate nutrition, with notions of being a good mother. Set in the context of wider policy debates about the links between food, health and obesity, it allows the exploration of the ways in which mothers of young children engage with these debates. To understand how mothers engage with notions of health, expertise, good/bad food and family meals this study explores women's discourses around these topics. Studying discourses allows an understanding of how mothers position themselves in relation these key areas, considering how they articulate their views of

food and family but also exploring what is implicit in their discourses. Discourse analysis allows identification of the broader meanings underlying the mothers' articulation of their views and experiences (Lupton, 2012). Engaging with mothers who have one or more children over the age of one but not yet at school, this study considers what information and advice mothers sought or received, how they engaged with that information, and how they think more generally about food and feeding their children. Including both first time mothers and mothers with more than one child will illuminate differences in views on feeding children as mothers gain experience, as well as allow mothers to reflect on how their practices differ between their first and subsequent children. Daily practice and self-reflection will be considered along with mothers' views of the 'experts' who advise them on feeding their children. In doing so this thesis will contribute to the understanding of the importance of feeding children to mothers, how they negotiate their feeding priorities with their sense of being a good mother, and the impact that 'other' individuals have on these relationships. In particular, the research will answer the research question:

In which ways do mothers of pre-school children, use, prioritise and privilege external information and advice on feeding their children, taking account of their views on feeding, feeding activities, and maternal experience?

This question will be answered by the following secondary research questions:

- I. In which ways do mothers negotiate expert discourses on how they should feed their children?

- II. How is the power of the expert experienced by mothers and how is that negotiated?
- III. In what ways do mothers negotiate, deploy and resist the discourse of good parenting (motherhood)?
- IV. How do mothers negotiate feelings of risk, control and success in relation to feeding their children?

Chapter 1 presents the literature that informed the framing of this research. It considers the ways in which mothers conceptualise, negotiate and experience good motherhood. It explores how mothers experience surveillance and how expertise is used to define the ways in which children should be fed. Mothering within a risk society is discussed alongside the presentation of literature on the continued gendered nature of care giving and the ways in which mothers account for their food provisioning. The public health policies that relate to feeding children are presented alongside literature on the understanding of public health messages. The chapter ends with a discussion of the influence of class on food decision-making. Chapter 2 outlines the theoretical underpinnings of my research, the methodology and methods used. It also presents details of the research process, analysis and presentation of the research results. The chapter concludes with a discussion of ethical issues along with reflections of my role as researcher within the research. The following four chapters present my data. Looking first at the ways that health, in relation to diet, is defined and prioritised, Chapter 3 considers the ways that mothers translate this understanding into food provisioning. It presents data on the ways in which mothers engage with the dominant discourse on the importance of health, considering the influence of their upbringing, concerns for the future and the place of enjoyment. Chapter 4 then looks at the important role of expertise and how experts impact on

mothers' negotiation of good motherhood. It considers the information mothers receive, or seek out, on feeding their children alongside a discussion of how they engage with this material. Mothers' awareness of other mothers is also presented, looking in particular at how they feel judged by or judge others. The ways in which mothers judge each other is further developed in Chapter 5 through the exploration of the opposition of good food and bad food. Using the discursive role of 'the biscuit' and 'the chicken nugget' it examines the ways in which particular foods symbolise different feeding strategies and representations of motherhood. It also presents the ways in which mothers negotiate good motherhood through defining what is important to them in feeding their children. Ideals of motherhood are explored further in Chapter 6 through discussion of the ideal of 'the family meal'. Through consideration of the 'family meal', issues of gender, sociality and women's role within the family are presented. Analyses from the previous chapters are brought together in Chapter 7, which presents a discussion of the research and how it can be used to answer the research questions. It then discusses the main findings in relation to existing literature, showing where they add to current debates. The relevance of this research to policy and practice is briefly discussed before concluding remarks are presented.

Chapter 1: Research Setting

Intensely social, boringly mundane, simple or complicated, at times eating seemingly connects to the very core of our selves, at others it is just a drudge activity necessary to keep body and soul together. (Probyn, 2000:1)

Feeding children is one of the many tasks mothers undertake on a daily basis. What children eat has gained greater prominence in health and political discourses at this time as experts engage in debates over the extent and causes of childhood obesity. What we eat as individuals arises from a complex set of interacting pre-existing dispositions and structural constraints, some of which are difficult to alter. Of central importance to mothers is their sense of being a good mother, both as a way of claiming a moral self and as a representation to the outside world. With pre-school children, mothers are at the centre of decision-making on feeding which occupies one of the major parenting roles in the early years. Women are advised on many aspects of childcare even before they become mothers, from pre-conceptual nutrition through to early infant feeding and care. To claim good motherhood status women are exhorted to pay attention to expertise on many aspects of child rearing from feeding and sleep patterns to education.

Mothers retain a central position in the decision-making processes which determine what children eat. In understanding why mothers make the decisions they do it is important to consider their dispositions, which are partly influenced by structural constraints. There are three interlinking areas of study that are crucial to our understanding of mothers' actions, decision-making and experience. Foucault (1977; 1988) considers the way that power is exerted through the surveillance of individuals, such that the individual is both aware of the gaze of others on

themselves and their own self-reflection. Mothers compare themselves to others as a means to achieve self-awareness and validation of their actions. Power is further exerted by experts who hold the knowledge of the best course of action to be taken by individuals and the mechanisms to monitor whether or not their expertise is being adopted (for example nutrition surveys in the case of food consumption). Such an individualised approach is indicative of the neoliberal society in which these mothers are negotiating their food decisions. Peterson and Lupton (1996) link current neoliberal societies with the individualisation of health, such that individuals must take responsibility for their decisions, according to their understanding of public health risks. Issues of risk must also be considered in mothers' food decision-making. Beck (1992) and Giddens (1991) both contend that we live in a 'risk society', conceptualised as a society in which risk management has become part of daily life. Risk takes two forms in the context of feeding children; the risks to health of eating the wrong foods (both immediate in relation to food poisoning and long term in relation to future health status) and the moral risks to mothers of feeding their children a diet that does not conform to prescribed notions of healthy eating. Beck (1992) and Giddens (1991) argue that the understanding of risk requires the mediation of experts with the development of scientific complexity in any field creating ever more distance between individuals and understanding. They also acknowledge, however, that increasing reliance on experts to understand risk gives rise to mistrust of some of the sources and forms of knowledge. Mothers must engage with experts to decide how to feed their children. Underlying this decision-making is the perceived fear of moral failure should their child not develop or grow in the ways expected according to this discourse, the most obvious being a child who is overweight or obese. Surveillance and risk therefore intersect through

consideration of expertise and how mothers negotiate different aspects of feeding their children. Overarching all of this decision-making are issues of class and taste, which are partly fixed, structural constraints and partly ambiguous and contested. Bourdieu (1984) considers the different ways class relates to a number of consumption practices, including food. Through his concept of 'habitus', Bourdieu (1984) shows the ways in which individuals adopt practices or 'life-styles' which are built on taste, that in turn function as symbols of status and distinction. Mothers must negotiate their dispositions, in different contexts in which surveillance and risk impact, to varying degrees, decisions on what to feed their children.

This chapter will locate my research contextually by considering the ways in which mothers conceptualise and experience good motherhood. It will then look at the ways mothers negotiate feeding through consideration of issues of surveillance, expertise and risk in relation to feeding children. Presentation of the literature will start with literature on the surveillance of families in 21st Century Britain, followed by discussion of mothering within a risk society. These sections will be followed by discussion of being a good mother, the gendered nature of care-giving and mothers accounts of food provisioning. Consideration of the public health agenda, the ways in which people understand public health messages and the key policies relating to feeding children, how they are framed and are informed by normative discourses will be presented. The section will finish with discussion of the influence of class and how that impacts feeding decisions.

Families under surveillance

Families in the early 21st Century in Britain are living in a society that could be characterised as neo-liberal, with the domination of the market and the reliance on

individuals making choices relating to all aspects of life, including health. Although the imperative for individuals to make the ‘right’ choices as citizens entered the Labour party rhetoric in the 1970s, it did not become the central focus of public health policy until the late 2000s, since when it has continued (Food Ethics Council, 2005). The ‘individualisation of health’ has become central to public health policy with individuals being held accountable for leading a health promoting life whereby they adhere to guidelines on many areas of life including: eating; smoking; drinking; exercising; being vaccinated; and exposure to the sun. Within these neo-liberal societies model citizens are those who accept the responsibilities given to them and adhere to public health guidelines (Lupton, 2013).

Such individualisation of health can be considered a mechanism of governmentality, an idea developed by Foucault to explain the way that power is exercised through a number of authorities, not only the State, in an attempt to govern the ‘wealth, health and happiness of populations’ (Rose and Miller, 1992:174). Of central importance to governmentality and the production of power, is ‘knowledge’, which is realised through ‘experts’ (Rose, 1992). Experts are thus essential as they both articulate and give substance to government priorities and make connections with individuals to help them act appropriately (Rose and Miller, 1992; Nettleton, 1997). Foucault considered there to be four ‘technologies’ of government, the two most important of which are ‘technologies of self’ (self-reflection and self-regulation, allowing individuals to govern their own actions) and ‘technologies of power’ (particularly power directing the conduct of others through surveillance) (Foucault, 1988; Coveney, 1998). These technologies or techniques can be seen as the mechanisms used to govern everyday activities across society (O’Farrell, 2006). Foucault (1977) saw the panopticon as an ideal mechanism of surveillance and

power, which he considered a productive power that would strengthen social forces. Based on Bentham's Panopticon, an architectural design for a prison building in which all cells faced a tower containing the unseen prison guard leaving the prisoners visible only to the centre but not each other (Foucault, 1977). Power therefore derives from the fact that the individual is constantly in a state of visibility such that surveillance is 'permanent in its effect, even if it is discontinuous in action' (Foucault, 1977:201). Foucault (1977) saw the panoptic schema as a way of exerting power over a group of individuals upon whom particular behaviours are required. The power of the panopticon is in its disciplinary power over society, as the power is exercised not only externally but from within in an ever constant presence.

Advances in nutrition science have resulted in new technologies of power, through the use of population surveys and the development of child growth charts, against which normality can be assessed (Coveney, 2006). Growth charts were initially used to predict and pick up failure to thrive in young children, the most extreme outcome of which would be child death, although they are still used to ensure child health, their use as a technology of power, as noted by Coveney (2006), has increased. In the global south where malnutrition was, and remains, much more of an issue, failure to thrive has been considered the responsibility of mothers who are both labelled as 'bad' mothers and targeted for educational intervention (Wheeler, 1985). As Wheeler (1985) points out these interventions pay scant attention to environmental or social constraints which affect mothers' ability to enact change, therefore, labelling mothers in this way does nothing to alleviate the problems. In the United Kingdom experts both define what it is to be a good parent (and mother in particular) and also judge whether an individual is living up to that ideal. As Lupton observes, 'While women's panoptic gaze is firmly fixed upon their

children, others are observing these mothers and making judgements' (Lupton, 2012: 14). The expert's role is important for parents to gauge normality in all aspects of bringing up their children from development and behaviour to eating and ultimately growth (increasingly focussed on weight). As John Coveney states:

'Expertise – in its many guises – thus produces 'good' parents: ones who can recognise themselves as having acquired the modern skills of parenting, in which enjoyment, health and, importantly, choice are central to the management of feeding the family.' (Coveney, 2008:237)

As will be discussed later in this chapter, parenting has become more than the ability to raise a child past infancy and childhood, and now encompasses the imperative to conform to a particular set of rules. Such rules of parenting encompass choices but failure to make the right or 'good' choices carries a moral risk (Lee, 2009).

Mothering in an age of risk

Moral risks associated with raising children arise in neoliberal societies, which are characterised by the individualising of health associated with changes in public health. The shift towards health improvement and increasing life expectancy has been called 'new public health' (Petersen and Lupton, 1996) and central to this new public health is the reliance on individuals to make informed choices about their health based on their knowledge of 'risks'. Risk in this context does not relate to everyday danger rather encompasses the relative merits of taking one course of action over another in terms of increased likelihood of ill health or disease or of moral jeopardy in living a particular 'lifestyle'. Individual knowledge of risk arises from the social and political context in which the experts, who are highlighting risks,

are operating and experts operate in many fields including and beyond public health (Douglas, 1992; Petersen and Lupton, 1996). The rise of health promotion has occurred in tandem with the individualisation of risk and although not envisioned as such has increasingly, in the UK, become premised on the assumption that individuals can control their chances of disease by understanding the risks posed by 'lifestyle' choices and acting to reduce these risks (Nettleton, 2006; Lupton, 1999). Within this discourse of individual responsibility for health, Petersen and Lupton (1996) contend individuals who choose to 'ignore risks' or, indeed, actively pursue risky behaviours, are vulnerable to criticism and the negative judgement of others, particularly those in positions of power. Writing on the particular implications for parents, Lee (2009) shows that this moral risk is particularly high for those who are tasked with making decisions on behalf of others, which impacts mothers more directly.

Sociological interest in risk derives largely from the work of Anthony Giddens and Ulrich Beck. Giddens argued that 'to live in a universe of high modernity is to live in an environment of choice and risk' (Giddens, 1991: 109). Giddens (1991) considered we live in a time where individuals want to control more aspects of life, which requires assessment of risk and the knowledge of what to do to minimise risk. He saw the main driver for individuals to be the desire to control the future, 'individuals seek to colonise the future for themselves as an intrinsic part of their life planning' (Giddens, 1991: 125). Beck considered 'knowledge' to be central to understanding and acting on risk; he saw 'risk' as something which was common in late modernity to such an extent that risk assessment became a normalised activity (Beck, 1992). Beck saw the individualisation of society as separating individuals from their traditional sources of support, leading them to rely more on 'experts' to

make risk assessments for them (Beck, 1992). This increasing reliance on experts he considered to be the ‘scientization of risk’ (Beck, 1992: 170), creating a wider gap between lay and expert knowledge such that the individual became more reliant on experts in assessing risks (Beck 1992).

Although acknowledging that individuals consider risk, acceptance of risk is not done uncritically. Lupton (1999) and Davidson et al. (1992) show through their work that individuals use their own experiences to build up lay knowledge through which they construct their own risk assessment. It is also the case that ‘people’s social location and their access to material resources are integral to the ways in which they conceptualize and deal with risk’ (Lupton, 1999: 117). In relation to feeding their families it is the ‘moral risks’ mothers encounter in living up to expectations of good mothering, the future health risks linked to dietary behaviour and the ‘risks’ they face in relation to food purchasing decisions which remain the most salient. These are, of course, only two areas of risk that mothers encounter in everyday life (risk to children include poor education; overall health; bullying; accidents; environmental pollutants).

The medicalization of food and health is seen nowhere more clearly than in the debates around infant feeding and, in particular, the debates over breast and formula milk. Murphy’s extensive body of research has shown the health and developmental risks of not adhering to the imperative to breastfeed are laid out clearly in medical rhetoric, leaving formula feeding mothers open to moral judgement by both health professionals and peers (Murphy, 1999; 2000; 2003; 2008). Whilst Faircloth (2010) argues that scientific evidence has been used to shut down the debate on the superiority of breast milk, the mantra ‘breast is best’ dominates infant feeding discourse in the United Kingdom. Some researchers have

questioned the force of the scientific certainty on the superiority of breastfeeding (Wolf, 2007; 2011) or the advice to exclusively breastfeed for six months (Fewtrell et al., 2011). Wolf argues that the presentation of the science on the power of breastfeeding to protect against a whole ream of potential future problems (from ear infection to low IQ and future obesity) is over stated, whilst using the established social norm that mothers will protect babies from harm to persuade mothers that breastfeeding is the only way to offer their babies protection (Wolf, 2007; 2011). Infant feeding² is highly prescribed with each stage requiring detailed advice on age of child and what foods are appropriate (both in terms of type and texture) with little room given for mothers to exercise judgement or call on experience (their own or that of others) (Murphy, 2003). Murphy's longitudinal study of first time mothers showed how their attitudes to professional expertise changed as their experiences of the reality of motherhood grew, with mothers talking of 'prioritising their babies' welfare' (Murphy 2000:309) as justification of their use of formula (Murphy, 1999; 2000). The dominance of the expert's discourse in her study left mothers feeling the need to justify their position of 'deviance' and to find other discourses in which to position themselves as 'good' mothers (Murphy, 2003). Health visitors are the health experts who have the most contact with mothers of pre-school children with the health visitors historically taking on the role of state regulator of infant welfare through their surveillance of mothers (Peckover, 2002). Peckover (2002) further suggests that the informal nature of health visiting is a way to disguise their role in state intervention. In her study, women described a tension between acknowledging the help they could receive from health visitors and concerns over revealing too

² Infants and babies refer to children under the age of one year with current NHS advice on food for children being defined by age group (6 months onwards, 12 months onwards, 2 years onwards www.nhs.uk/start4life).

much that could then have detrimental consequences for their families (Peckover, 2002). Health visitors could be seen to have disciplinary power (Peckover, 2002), linking to the work of Foucault (discussed above), further, occupying a position which Nettleton (1992) described as a ‘double-edged sword of welfare and surveillance’ (Nettleton, 1992:149). This is not to suggest that most mothers view health visitors negatively. An online study of over four and a half thousand mothers found two thirds rated their health visitor service as either good or very good and named health visitors as the first point of reference for issues relating to child development and behaviour (Russell and Drennan, 2007). Maunders et al. (2007) found the personal relationships built between a health professional and mother were important in mothers’ satisfaction, with the key being a health visitor’s ability to recognise mother’s expertise and tailoring specific advice to an individual woman’s situation. Pressures on health visitors, through increased caseloads and additional child protection work, can result in busy clinics with high staff turnover, both of which have been cited as leading to a lack of continuity in care and an overall decline in service (Russell and Drennan, 2007). It is precisely these pressures that make it difficult for health visitors to take the time to build relationships with mothers and tailor advice accordingly.

In addition to the moral risks associated with feeding infants incorrectly, there are also health risks associated with the food that we eat. These risks can be seen as long term, linking the food we eat with long term health outcomes, or short term, associated with a particular food stuff or producer, for example salmonella in eggs in 1988. The longer term risks associated with eschewing a ‘healthy balanced’ diet will be considered further when I look at parents’ understanding of public health messages and dietary motivations within families with young children.

In relation to potential risks posed by particular foods or producers, individual consumers are generally unaware of any threat caused by bacteria or other contamination that they cannot see for themselves. Consumers have inevitably come to rely on experts to let them know when something goes wrong with the food system, leaving most consumers to trust the food supply system until they are told something to the contrary (Green et al., 2003; Draper and Green, 2002). Dowler et al. (2006) argue that as food production and new food technologies become more complicated (for example genetic modification (GM)) lay individuals have more difficulty in making risk assessments. This, in turn, leads to the need for further expert information and, as a consequence, more uncertainty, linking directly back to the work of Beck (1992) and Giddens (1991). The need for outside information becomes important as individuals have to make judgements on the trustworthiness of a variety of information sources from which information flows. In the UK, politicians and policy makers are not trusted when they assert the food system is trustworthy and its products safe (Draper and Green, 2002), which the authors suggest could be the legacy of the political handling of the BSE (Bovine spongiform encephalopathy) crisis in the United Kingdom in the late 1980s. Shaw (2004) found that information derived from a scientific source is generally considered trustworthy, however, when there is no consensus (such as the safety of GM) individuals reject advice, preferring to trust in their own assessment. Experts and consumers both recognise there is a lack of understanding around food risks and that both groups need to be involved in 'bridging the gap', although there is disagreement on why the lack of understanding has arisen: experts blame a lack of knowledge and consumers a lack of transparency (Krystallis et al., 2007).

Wandel (2004) has shown that individual feelings of uncertainty about food safety is independent of education level, but trust in nutrition expert advice increases with education level, arguably leaving the better educated groups in society feeling more confident to act on that advice. Although experts highlight risk and impact on awareness, decisions by the consumer on what to do with that information are influenced by a myriad of factors. Green et al. (2003) and Shaw (2004) both show that for many consumers cost issues outweigh 'risks' in relation to food purchasing, leaving them little choice. Shaw (2004) further argues that for many the pleasure of eating something considered risky (for example a runny egg yolk, for pregnant women or the elderly) is greater than the perceived risk, therefore, is something that an individual would be reluctant to forgo. Differences in risk perceptions, which have been shown to affect food choice, are further affected by individual personal experience (Lusk and Coble, 2005; Leikas, 2007). Experience can result in an individual downplaying of risk, as found in older people who have lived through many crises and see modern society as over cautious (Green et al., 2003), or avoidance in those who had experienced food poisoning (Shaw, 2004). Ability to control risk, or a sense of being able to control it, and distance between exposure and effect, are also important. Shaw (2004) shows this as her research showed individuals felt they had more control over risks from eggs (change cooking method or change purchasing habits) compared to BSE, which is distant both in time and in experience (few people personally know an individual affected by the resulting disease). None of these studies has looked in particular at how mothers negotiate these risks when decision-making on feeding their children, but the ways in which they make decisions for themselves will affect their decision-making on behalf of others they are feeding.

Parenting is bound up with decision-making that starts ante-natally and continues throughout the child's life. Food risk (encompassing both short term food borne risk and long term food related health outcomes) is only one of many risks that parents must assess and act on (e.g. ante-natal screening; vaccination; child care; road safety; recreation activities). Jones (2008) found that 'science', compared to 'lay' knowledge, was considered as a valued and neutral source of information by parents making the decision to have ante-natal tests carried out, as did Hobson-West (2008) in her study of parents' vaccination decision-making. Whilst 'science' is framed as an authoritative voice by public health bodies, clinicians and parents, Hobson-West (2008) found those who are critical of mass programmes of vaccination could also frame science as biased, particularly in relation to the interests of those who fund scientific research (which in the case of vaccination includes large pharmaceutical companies).

Although taking account of 'risk' from immediate food-borne risk to the inherent riskiness of everyday life is accounted for in decision-making, a study by Green (2009) found that it was not a dominant discourse, rather it was one that was discussed only when raised by the researcher. Green argues that researchers looking at issues of 'risk' may raise the issue with participants willing to participate in research, but that 'this obligation does not necessarily imply any privileged place for risk discourses in everyday arena.' (Green 2009: 505). Whilst this argument may hold true for discussion of inherent everyday risk, the same could not be said about the moral risks of failing to provide a healthy balanced diet, as will be explored. Moral risks are immediately tangible to mothers as they are intimately bound up with definitions of good motherhood, yet they are not addressed directly by experts who are arguably complicit in their production.

Being a good mother

Sharon Hays first wrote about intensive mothers in 1996, when she described the ideology of intensive mothering as ‘a gendered model that advises mothers to expend a tremendous amount of time, energy, and money in raising their children’ (Hays, 1996 : x). Writing at a time when society was focused on individualism, self interest and personal gain, this growing ideology, where women were expected to put their child’s needs over their own, seemed to Hays (1996) to be a ‘cultural contradiction’. With continued emphasis on neoliberalism, intensive mothering has come to symbolise the norm, or at least an aspirational norm (Vincent, 2010). Whilst motherhood norms are socially constructed, some norms, such as intensive mothering, are hard to discard with mothers using them to claim a moral self (May, 2008; Vincent, 2010). In doing this, Shirani et al. (2012) and Vincent (2010) argue that the burden of responsibility for putting children first is directly laid on mothers.

Continued medicalization of health, alongside the rise of the expert, has left mothers’ decision making over childcare (from the first decision to breast or formula feed) open to question (Andrews and Knaak 2013). Ristovski-Slijepcovic (2010) shows that the work of keeping abreast of scientific development and translating that into family practice is also incorporated into the role of ‘good’ mother. An integral part of this role is the monitoring and surveillance of the family and assuming the individual responsibility for family health through which mothers represent a technique of governmentality (Ristovski-Slijepcovic, 2010). Being a healthy citizen and creating a healthy family by following a ‘healthy lifestyle’ involves mothers in making sure their children are offered a healthy diet, encouraged to participate in physical activity, receive the appropriate vaccinations and have enough sleep. The 1990s saw a focus on brain development which emphasised the importance of the

early years in developing a child to its full potential with the burden of doing this development falling squarely on mothers (Wall, 2010). Wall (2010) found that mothers have taken on this added responsibility without questioning whether, and to what extent, they could affect their child's developmental outcomes. Her study was with middle class, well-educated women and it is arguable whether the same would be found in families with fewer social and economic resources.

Taking on all the responsibilities of intensive mothering requires time and resources, which are not equally available to all mothers. Intensive mothering privileges those with money and those with a partner, which Vincent (2010) and Leigh et al. (2012) argue leaves those experiencing poverty, especially single parents being judged as inferior parents through their inability to conform to the middle class norm. Vincent and Ball (2007) and Vincent (2010) argue that working class mothers see their role as nurturing and protecting their children, allowing them to develop in a naturalistic fashion with more fixed characteristics, skills and talents whilst middle class mothers see their role as one of developing and enhancing their children by giving them life skills which will lead to enhanced future life chances. Vincent and Ball (2007) contend that middle class parents justify enrolling their children in pre-school classes as forward planning, something they can do owing to their economic capital, which gives them the capacity to buy expertise when needed. Not all middle class parents want to buy into these life-enhancing activities as Perrier's (2014) study showed many worried about additional pressure being laid on their children and therefore rejected this expectation. This, of course, was done out of choice rather than owing to capital constraints. There are commonalities amongst all mothers regardless of class, including the need to decide between what is desirable and what is possible, making compromises as required, whilst justifying their decision to allow

them to position themselves as ‘good mothers’ (Leigh et al., 2012). Furthermore, Leigh et al. (2012) argue that taking responsibility, not only for current health but also for the future of their children, is emotional labour, which is disproportionately borne by women. Through this expectation of producing responsible citizens for the future, Lister (2006) contends, private becomes public. The scrutiny and questioning of mothers’ actions in relation to the social norms of intensive parenting, Shirani et al. (2012) suggest, leads to parents drawing on the notion of the ‘other’ to describe those who are falling short of expectations. The notion of the ‘other’ is in opposition to the middle class parent who is responsible, self-sufficient, and most importantly, reflexive, weighing up advice before accepting or rejecting expert opinion (Shirani et al., 2012). It could be argued, however, that such social norms are not equally felt by all mothers and that middle class parents are both more aware, and accepting, of the norm of intensive parenting. This too can lead to more anxiety over issues of risk and surveillance as they take on ever greater responsibility for myriad aspects of their children’s lives. Working with mothers from different social backgrounds, Bloomfield et al. (2005) found, across all groups of mothers, a constant need to compare themselves with ‘others’ resulting variously in feelings of failure and guilt, coupled with the acceptance that being a ‘good enough’ parent was sometimes the best they could do.

None of this assumes that parents or mothers are passive in the acceptance of expert opinion on, or advice about, ‘good parenting’. Parents are more dependent on experts in their early days, with parents developing more self reliance as they become confident in reading their child and understanding its needs (Miller, 2005). Expectations of motherhood run high and living up to an ideal can be problematic as Miller has found:

The myths which continue to come to shape these expectations in many Western societies are the co-productions of health professionals, authoritative medical knowledge and other mothers.

(Miller, 2005:147)

Media portrayal of women as mothers, which are typified by the late 1990s categorisation of mothers into the so-called 'Yummy Mummy' and the 'Chav mum', cast these mothers in direct opposition to one another (Allen and Osgood, 2009). Allen and Osgood (2009) show that the 'Yummy Mummy' is epitomized by consumerism, celebrity and glamour with the neoliberal ideal of choice making (and making the 'right' choices) at its core, whilst the 'Chav Mum' is portrayed as every working class young mother who is fat, lazy and on benefits. Tyler (2013) sees the construction of the 'chav' as the result of neoliberal governmentality whereby particular groups in society have been vilified; young single mothers seen as feckless scroungers. She goes on to contend that the construction of the 'chav' through the technologies of government, ideological belief and economics has resulted in the casting of citizens who are economically disadvantaged as socially abject (Tyler, 2013). Littler (2013) considers the 'yummy mummy' as 'deeply constricting in its promotion of its hyperfeminine heterosexual form of maternalism' (Littler, 2013: 238). These oppositional portrayals of motherhood play out daily in tabloid newspapers, daytime television programming and websites dedicated to the pursuit of perfect parenting. Discourses of good parenting are therefore constructed which value delayed parenting, financial security and stable relationships. It is not surprising, therefore, that Hey and Bradford (2006) found young mothers living in deprived areas see themselves as stigmatized and their children being limited by their circumstances. Furthermore, Kirkman et al. (2011) found young mothers felt judged

by older mothers who need not make overt comments to be felt as judgemental. All is not easy for the ‘yummy mummy’ either as Wall (2010) found intensive mothering requires a great deal of emotional and physical energy and the scrutiny which, along with fear of failure, often leaves mothers feeling stressed, anxious, guilty and exhausted. Furthermore, Littler (2013) argues that the continuation of the recession has led to a downplaying of the material excesses of the ‘yummy mummy’ in favour of a popular mother figure which is more balanced. None of these studies looks at the particular issue of feeding children yet issues of scrutiny, surveillance and the gaze of others are all relevant to consider when considering the experience of mothers in making food-provisioning decisions.

Nelson (2010) suggests middle class parenting is fraught with anxiety about both the future and current dangers, whereby parents have to decide between pushing children to achieve and putting too much pressure on them. When asked about what concerned them most about children in the community, parents cited their greatest concerns to be ADHD (attention deficit hyperactivity disorder), internet safety, obesity, smoking and bullying but when they were asked about what they were most concerned about with regard to their own children, top of the list were nutrition, obesity, lack of exercise and healthy growth and development (Garbutt et al., 2012). Priorities reflected age group; with parents of younger children (age 2-5years) being more concerned with behaviour, those with children aged 6-11 years with bullying and those with children aged 12-17 with depression (Garbutt et al., 2012). Above all, this shows not only that parents’ priorities change over time, as their children develop and grow, but that parents see ‘other’ children differently from their own with a tendency to see the broader societal problems of ADHD, bullying and internet safety as risks others face.

Good mothering may be achieved through the combination of decision-making, emotional labour and consideration for the future. However, it is no longer sufficient, as a parent, to rely on your experiential knowledge and your instincts to bring up your own children whilst claiming good motherhood. Rather, experts are now required to oversee all elements of child rearing from sleep routines and discipline to nutrition and education. The reliance on expertise through which to claim good motherhood is epitomized in the rise of parenting classes or parenting programmes designed to help parents be more effective (Vansieleghem, 2010; Lee et al., 2010; Smeyers, 2010). Lee et al. (2010) link this rise to increasing anxiety over risk, claiming as society is deemed ever more risky, potential risks to children become greater and the more parents need to be aware of every possible risk from the internet to what they eat. Furedi (2002) argues that this results in parents being required to be vigilant about potential dangers from the moment their child is conceived. He further contends that ineffective parenting is publicly blamed for many societal ills ranging from eating disorders to violence in boys (Furedi, 2002). Furedi (2002) believes that this culture de-skills parents who need to regain confidence in their knowledge of their own child, relying on experts for specific information. He suggests that the growing need for experts to teach parents is based on a false premise:

Professional intervention rests on the bureaucratic conviction that
because parenting has got to be learned, it must also be taught.
(Furedi, 2002:19)

Whilst these researchers argue that the normative discourse of good motherhood status requires investment in professional parenting and the consultation with experts, they do not consider the many mothers who do not pursue the 'expert' led

path in their parenting decisions. Many mothers do not seek out expertise, rather they construct their own versions of being a good mother defining it in their own terms. Some of the differences in engagement with expertise, in relation to parenting, are class-based and these will be discussed below. The steady progress of professional intervention in ever more spheres of parenting is highlighted by recent plans, unveiled by the then women's minister and culture secretary Maria Miller who stated that 'Ministers are planning to produce information packs for the parents of daughters to help them to bring up "aspirational" young women' (Boffey and Stewart, 2013). Maria Miller was in a very small minority of female cabinet ministers; furthermore, the plans unveiled paid no attention to the structural issues that affect young women's attainment. This example further illustrates the government reliance on expertise in relation to parenting which further condemns parents' experiential knowledge as irrelevant. Exhortations from politicians and other bodies in positions of power do not fall on parents equally. The gendered nature of care giving has been the focus of study for some time with the burden of responsibility being unequally felt by women.

Gendered Nature of Care-giving

Research in the 1980s and 1990s highlighted the extent to which caring work in general, and food work in particular, was the domain of women. Hochschild (1983) showed that women were expected to provide the psychological support in families owing to their perceived emotional suitability. Researching food and families, Charles and Kerr (1988) highlighted the importance of food as a symbol of family and social relations and the importance of home cooked meals, cooked from scratch with the important ingredients of meat and vegetables. Women were expected to be able to cook and take on the child care responsibilities but, for the

women in this study, increased knowledge left some women feeling more insecure rather than able to make better choices, whilst increased nutrition education increased feelings of guilt rather than changing eating patterns (Charles and Kerr 1988). De Vault (1991) carried out similar work, looking at food in families in the USA, and similarly found women taking on the burden of responsibility for cooking, regardless of work outside the home. Although much food decision-making is consensual within families, research has repeatedly shown responsibility lies with women (De Vault, 1991; Henson et al., 1998; Graham, 1993). Graham (1993) found that where men take on some child caring tasks they are more likely to undertake the less mundane tasks of bathing and putting children to bed rather than nappy changing and feeding. She also found that young women in particular feel their partner's involvement is enough as they rely on them for emotional and economic support and thus feel unable to question their role (Graham, 1993). More recent research shows little has changed with women remaining largely responsible for food provisioning, crucially taking on the responsibility and decision-making roles even where their partners are involved in some food preparation (Stapleton and Keenan, 2009; James et al., 2009; Wilk, 2010). Stapleton and Keenan further show that becoming a mother seems to change responsibilities even in partnerships where food was previously a shared responsibility, with food being 'perceived as integral to the maternal role' (Stapleton and Keenan, 2009: 48).

As Smart (1996) argues, motherhood and its accompanying roles and responsibilities are not fixed rather are socially constructed and as such change over time as expectations of mothering change. But there is little evidence that mothers are resistant to the ideology of motherhood, although it is clear as shown by Choi et al. (2005) that the reality of becoming a mother rarely lives up to the myth, often

leaving mothers feeling inadequate. It is mothers' performance of the expected tasks of motherhood that are scrutinized by health visitors, social services, doctors, teachers and other mothers, looking for evidence that individual mothers are behaving like responsible citizens in taking care of themselves and their families (Smart, 1996). This unequal burden on women is clearly seen through work by Lister (2006) and Grover and Mason (2013) who show that working with families and focussing on family health, as policy documents suggest, really means working with women and mothers who are then obliged to take on the burden of responsibility for family health and wellbeing. If it is then the case that women are taking on this burden it is important to consider their accounts of how this is lived on a daily basis.

Mothers' accounts of food provisioning

Whether taking on the responsibilities for food provisioning gladly or out of duty, women are faced with food provisioning tasks on a daily basis, regardless of whether or not they work outside the home. There is a wealth of research that shows how mothers talk of an 'ideal' whereby they will provide home cooked meals, which include fresh products, that are cooked from scratch and enjoyed together (Madden and Chamberlain, 2010; Slater et al., 2011; Stead et al., 2004; Mosio et al., 2004; Rawlins, 2009). This 'ideal' is hard to achieve on a daily basis, therefore, mothers act in pragmatic ways to assuage their feelings of guilt but allow them to provide food for their families that their families will eat, even if each eating event is neither done together nor enjoyed by all (Slater et al., 2011; Stead et al., 2004). Time pressures and busy lives mean mothers rely on more pre-prepared foods and take-away meals than they would like and admit to buying and preparing fewer of the foods (most notably fresh vegetables) that they feel they should provide, but that they know will be wasted (Madden and Chamberlain, 2010; Slater et al., 2011).

Moisio et al. (2004) found that despite the constraints on families, the importance of conveying family unity through family meals was achieved through the transformation of food at home. This was the case even when elements are pre-prepared elsewhere, which was of great importance to women who feel the burden of trying to keep the idealised family together (Moisio et al., 2004). Although this ideal is important it is also ever changing as Valentine (1999) outlines through considering the many ways that family meals are negotiated and change over life courses. Kaufmann's (2010) research on the meaning of cooking shows that the ideal may be sought but that there are many times when family meals are challenging and far from enjoyable, causing much anxiety for all participants, not only mothers. When additional problems, such as perceived 'picky' eaters arise within families, Wilk (2010) shows the ideal is further challenged as mealtimes become fraught with additional meaning beyond commensality and the ideal of good mothering.

Whilst mothers are dealing with all the pressures outlined above, they also have to deal with structural and environmental factors including income, cost of food, proximity to food outlets, and facilities in the home. Work by Caton et al. (2004) shows the importance of experiential knowledge, as the mothers in their study looked more to family and friends rather than official guidelines when deciding how to wean their children. Knowing a particular strategy had worked elsewhere was important (Caton et al., 2004). Despite research to the contrary, experts, who advise mothers on what they should be feeding their families, still regard a lack of knowledge and cooking skills as the key factors in determining what is eaten in the home. The knowledge / skill deficit argument amongst certain groups persists despite extensive research evidence that continues to show that these elements are low on the list of factors affecting food provisioning (Caraher et al., 1999; Stead et

al., 2004; Slater et al., 2011). Jackson (2010) shows that there is a gap between expert advice and the everyday realities of those on low incomes who he considers have little choice but to buy what they can afford in a bid to feed their families with little waste. Food provisioning decisions are not taken unthinkingly, as Heflin et al. (2005) show food insecurity adds to the pressures on mothers, leading to increased incidence of depression in mothers of food insecure households. It should also be remembered that food provisioning might be routine and rarely regarded as an intellectual pursuit but as Meah and Watson point out:

It has also become more complex in relation to volume of information available on how to cook safely, healthily, tastily, on budget, for a family, for guests, for oneself, and in terms of the range of knowledge and skills necessary to negotiate contemporary technologies of food provisioning, from use-by dates to microwave defrost programmes. (Meah and Watson, 2011: 2)

Food provisioning decisions are complex and include all the elements outlined above, even if not consciously considered on a daily basis. Rhetoric in many professional and public policy areas alludes to a time when mothers made home cooked meals, families sat around tables and there was less reliance on processed foods. It is clear, from the research shown here that the ideal of family meals, cooked from scratch where possible, persists although has to be negotiated to fit with dual working households and families working on different time schedules. Short (2006) considers all these arguments when she calls for perspective on the changes in food provisioning that have occurred, along with the changing skills required, rather than looking back with misplaced nostalgia to some golden era of home cooking that

never really existed. How public health policy engages with these debates and ultimately provides advice for the public is now examined.

Health and the Role of Policy

The state's interest in the food we eat derives, in part, from the links between nutrition and disease, which are backed by sufficient evidence to show they make an impact at the level of the population, whilst also being of importance to individuals and society (Lang et al., 2009). Policies to affect change in the diet of a population can be aimed at the level of the individual (for example: education, information, labelling) or, they can be levelled at the population or to influence society change (for example: structural or fiscal measures, regulation of food composition or regulation of advertising) (Lang et al., 2009, Milio, 1989). The former can be considered politically and economically less costly whilst the latter are deemed more costly in both political and economic terms. The role of the market must also be considered alongside policy with Tansy and Worsley (1995) noting that the market-drive to increase the value added element of food products has led to problems of both health and sustainability. Much of the focus of the food system during the 1980s and 1990s was on cheap food and maximum profit but by the late 2000s the cost of such systems were being questioned by the UK government in relation to the cost to health, attributing much of these costs to the rise in obesity (Lang et al., 2009).

Despite its non-individualised conceptualisation, and efforts through health promotion to consider the wide variety of settings in which action can occur, much of the public health focus in the United Kingdom has become and remains individualised. Alan Petersen and Deborah Lupton (1996) are critical of the

individualisation of public health which they argue is entreating individuals to take responsibility both for themselves through attention to ‘lifestyle’ and ecological issues through collective action. Further, Petersen and Lupton consider:

The discourses of the new public health also seek to transform the awareness of individuals in such a way that they become more self-regulating and productive both in serving their own interests and those of society at large. (Petersen and Lupton, 1996:12)

Petersen and Lupton (1996) consider the concept of risk as central to the new public health focus with health promoters entreating individuals to live rationally in light of these risks. The current UK government makes the following claim for public health:

Public health is about helping people to stay healthy, and protecting them from threats to their health. The government wants everyone to be able to make healthier choices, regardless of their circumstances, and to minimise the risk and impact of illness.
(Gov.UK, 2013)

This statement carries an underlying assertion that individuals are therefore responsible for making these choices along with the assumption that there is agreement on what constitutes a ‘healthier choice’ and by making one individuals are minimising the risk to their own health. Hunter (2003) notes that public health policy in the late 1990s called for upstream initiatives, including Health Action Zones and Healthy Living Centres (see Dowler et al., 2007), but that many of these were not implemented or followed through with sufficient resources. Comparing the forewords of policy documents from the late 1990s and mid 2000s Hunter (2005)

goes on to conclude that the tone changed from a focus on government assistance towards more individualised responsibility and increased marketisation of health. In subsequent analysis of public sector reform Hunter et al. (2010) focus on the increased reliance on markets and choice, arguing that this agenda will negatively affect health inequalities as those with more resources and who are health aware will be better able to benefit from available choices.

Taking individual responsibility relies on people making the ‘right’ choices when given enough information. Martin Wiseman, head of the Nutrition Unit at the Department of Health, considered the administration he worked under to be focussed on individual responsibility, which relied on the availability of information and individual ability to interpret it usefully (Wiseman, 1990). He further summed up the difficulty of bridging the gap between science and the public by stating there was ‘almost direct competition between accuracy and simplicity of information’ (Wiseman, 1990: 399). Of course, the ‘right’ choice in this context is that which will promote health as defined in health policy not what is ‘right’ for a mother balancing her budget, stopping her children from being hungry or managing her time effectively. Although there is an acknowledgement that other factors (including social, cultural, economic, psychological and environmental) affect our health and wellbeing the rhetoric of individual choice and responsibility is strong, as illustrated by the Government White Paper on the NHS (DOH, 2010a). This policy paper clearly places the responsibility with individuals. ‘In return for greater choice and control, patients should accept responsibility for the choices they make, concordant with treatment programmes and the implications for their lifestyle’ (DOH, 2010a :16). In other words, individuals must be responsible for their choices but also for

any treatment they may be offered on the NHS, irrespective of its relevance and salience to their structural position.

In the policy climate of individual responsibility, responsibility for children requires a ‘whole family approach’ whereby parents and grandparents are called on to ‘model’ positive lifestyle choices, although, in practice most of the policy documents outlined above focus on mothers as the key individual responsible not only for her own health but that of her children from conception through childhood. These policies are based on a knowledge deficit model whereby much of the reasoning given for individuals not conforming to the recommendations from shopping to cooking are blamed on a lack of knowledge without reference to structural constraints.

Government policies that focussed on tackling obesity (DOH, 2008; Cabinet Office, 2008) had the improvement of the health and wellbeing of children and young people as principle drivers (Caraher et al., 2009). Although these policies emphasised the need for action by the many players involved in health, the role of the private sector was highlighted through the ‘Responsibility Deal’, drawn up in 2009 by the Public Health Commission and launched in 2011. The Public Health Commission was established by the then Shadow Secretary for Health, Andrew Lansley, and emphasised the role that business could play through partnership with Government, but, importantly, without the need for legislation, by means of voluntary agreements. Voluntary agreements were not new and had arguably had some success, for example in reducing salt levels in processed foods (FSA, 2008), and were further developed through the government’s new social marketing campaign.

Commercial partnership is an essential element of the strategy which took forward and developed *Change4Life* (launched in 2009) as the major social marketing campaign. There is, however, little discussion of the role of commercial partners and their use of the *Change4Life* logo in their own marketing strategies. At the centre of the campaign are eight ‘behaviours that parents should encourage their children to adopt if they are to achieve and maintain a healthy weight’ (DOH 2009:8) clearly requiring individual parents (in reality mothers) to monitor their children with regard to these eight behaviours. Strategies like *Change4Life* are criticised as being too simplistic in ignoring the complexities of real life or dealing with the barriers to healthy living (Rayer and Lang, 2011; Bonell et al., 2011). Rayner and Lang (2011) take that criticism further by asking whether such activities are a form of collusion between the state and corporations. An argument addressed by Panjwani and Caraher (2013) in their analysis of changes to the calorie reduction pledge between draft and final formulation in the Responsibility Deal. Panjwani and Caraher (2013) argue that private sector interests have been afforded an opportunity to influence policy in their favour without sufficient measures to evaluate or monitor activity. Further, they argue that a lack of incentive or sanction will mean the potential to improve public health will be missed and indeed the expectation that such voluntary agreement will deliver on public health over public sector interest is misguided (Panjwani and Caraher, 2013).

There has been a great deal of policy work spanning the last twenty years which has relevance to the food and health agenda but which is too extensive to detail here. It is worth briefly considering the attention paid to health inequalities over that time which centre primarily on the work of two reviews: Independent Inquiry into Inequalities in Health, Acheson (1998); and Fair Society, Healthy

Lives: The Marmot Review (2010). Acheson (1998) highlighted mothers' health and the health of children as key areas that could have potential impact on reducing inequalities. The review called for changes in taxes and benefits alongside other poverty reduction measure and was influential in the framing of the government policy, *Our Healthier Nation* (DOH, 1998). The second independent review, *Fair Society, Healthy Lives* (Marmot Review, 2010), was tasked with setting out the most effective, evidence based strategies to reduce health inequalities. The Marmot Review (2010) showed a clear pattern of declining health linked to socio-economic status, echoing findings from the past twenty years including the work by Acheson (1998). Taking the broader context of people's lives into account, it recommended action linked to 'life course' (Marmot, 2010) which was not new but was adopted by policy for the first time. The Government White Paper (DOH, 2010b) adopted this life course framework and emphasised the need to consider the wider context, a positive recognition that the issues are multifaceted and that policies must take structural issues into account alongside the often focused upon 'lifestyle' choices (DOH, 2010b). Particular emphasis was given to what the Government labelled 'Starting Well', targeting women before, during and after pregnancy, with a view that doing so will lay the foundation of a healthy life for their children, thereby ensuring healthier citizens for the future (DOH, 2010b). The importance of tackling obesity was also emphasised in what the Government labelled 'Developing Well', where it is rather emotively claimed that 'Through social networks, obesity can actually be 'spread' by person-to-person interaction' (DOH, 2010b:19). The targeted changes and improvements were to be made through locally controlled and delivered services, giving power, and with it responsibility, to the individual. The government stated 'We need a new approach that empowers individuals to make healthy choices

and gives communities the tools to address their own, particular needs' (DOH 2010b:2).

To help deliver the targets set out in the 2010 White Paper, the Department of Health produced a three year social marketing strategy for changing health related lifestyle behaviours and improving health outcomes with a continued focus on 'lifestyles' and the imparting of knowledge (DOH, 2011). The policy stated that 'To ensure sustained change people need motivation, ongoing support, immediate feedback and frequent reminders.' (DOH, 2011: 14). In relation to diet it suggested action to address 'low levels of understanding about what constitutes a healthy lifestyle (such as how to shop for, prepare and provide a healthy diet)' (DOH, 2011:15). 'Information' is again highlighted as a key factor in helping individuals make appropriate choices on a range of issues from choosing their GP practice, which should be based on performance-related information, to the food that consumers buy (DOH 2010b). Information on what is in the food that we buy, or indeed what food should be consumed, is given a great deal of attention by government policy documents taking a neoliberal approach but knowledge about food is only one small element of food choice decision-making. It should not be forgotten either that these policies fall under the auspices of the Department of Health which is responsible for 'individual' level health whereas Defra (Department for Environment, Food and Rural Affairs) governs the production and safety of the food system. Legislation on advertising, labelling and planning all of which affect the ways that individuals interact with the food system are regulated and legislated on by a myriad of other government departments. Knowledge about 'healthy' lifestyles and skills (in this case relating to cooking) remain central to the current

government's policies with little critique of how individuals access and understand public health messages.

Understanding public health messages

As discussed above, a move towards a more neoliberal style of government within the UK has led to a greater emphasis on the role of the individual in maintaining their own health. Nettleton (1997) draws on the work of Foucault to show the ways in which individuals are required to take responsibility for their own health in order to be good members of society. She further argues that systems of government exercise power through political, ethical and institutional forces (Nettleton, 1997) which become relevant in relation to health as the individual is entreated to be aware of the health risks around them and to take action to minimise or prevent such risk. Public health, through health promotion, employs experts who provide the knowledge to allow individuals in the population to lead a 'healthy lifestyle' which Nettleton points out requires: "the emergence of a person who acknowledges that he or she is able to contribute to his or her own health, wealth and well-being" (Nettleton, 1997:220). Individuals are thus encouraged to follow a 'healthy lifestyle', which is characterised by refraining from smoking; drinking within guideline limits; eating a healthy diet, as defined by nutrition experts; and meeting other experts' guidelines on physical exercise. The various guidelines and recommendations are conveyed through advertising, public health leaflets, manufacturer information, school based education and health professionals. In order to present themselves as good citizens, parents must also fulfil their moral duty not only by following the recommendations for themselves but by implementing them within the family. How recommendations are understood is therefore crucial to the public health agenda and to parents trying to fulfil these obligations.

Public health experts try to simplify food messages in an attempt to make them understandable but in so doing rely on individuals having a basic understanding of scientific issues, a situation which cannot be assumed (Coveney, 2004). O'Key and Hugh-Jones (2010) have shown that science is highly regarded in relation to health messages as individuals consider information backed by science, especially when conveyed by government sources, to be more trustworthy than that conveyed by other sources, with information originating from manufacturers being the least trusted. Rangel et al. (2012) found health to be a centrally organising principle governing food choice for the women in their study, but knowledge that there were risks (both known and unknown) in food, along with what were deemed contradictory nutritional messages, left many women feeling anxious about which foods to choose. Such anxiety is not only felt for oneself but women take on the burden of responsibility of interpreting messages and making food decisions for themselves and their children, with food seen often as an adversary requiring control through systemised choice and dietary regimen (Rangel et al., 2012).

Whether actively seeking out information on food health or passively coming across such information through advertising, women are often targeted, particularly when it comes to advertising products aimed at children. Advertising claims are interpreted through pre-existing knowledge, particularly if scientific claims are being made, with Dodds et al.'s (2008) study showing them to be more readily accepted if they are simple and fit with pre-existing health knowledge. Studies which have reviewed the content of advertising show that mothers' anxieties are exploited by advertisers who then offer products to assuage their anxiety, linking good mothering firmly with the provision of healthy food, and giving mothers a solution for their feeding dilemmas (Coutant et al., 2011; Manganello et al., 2013). Mothers are

concerned by the amount and type of food product advertising on television (Morley et al., 2008) but at the same time they have also been found to accept claims of some products, most notably baby milk, relatively uncritically (Berry et al., 2010). When purchasing foods, information on labels is referred to by some mothers but this is not a simple process as a study by Eden (2011) found the more processed a product, the more difficulty mothers had in understanding information on the label.

Manufacturers also use selective information to market a product as ‘healthy’, which Smith and Freeman (2009) demonstrated in their study of oral health in Scotland was a source of confusion. Mothers purchased cereal bars as a perceived healthy snack unaware of their sugar content, therefore, their detrimental impact on oral health (Smith and Freeman, 2009). Cooper et al.’s (2011) systematic review of all articles giving dietary advice in British newspapers demonstrates why public confusion is not surprising. During the week surveyed, nearly two thirds of the articles scrutinised were found to lack sufficient evidence to comply with either WHO³ or SIGN standards (Cooper et al., 2011). This, they claim, adds to confusion and therefore they were not surprised by the findings of another survey which showed 52% of UK residents thought scientists were always changing their minds leaving 27% reporting they ignore dietary advice as a result (Cooper et al., 2011). As mothers have to make these decisions on behalf of their families, unclear or seemingly contradictory reporting adds to uncertainty. None of these studies reported whether mothers’ views on advertising change over time, as their children grow and change their nutritional requirements, or as they, as mothers, become more confident in their feeding decisions.

³ WHO: World Health Organisation; SIGN: *Scottish Intercollegiate Guidelines Network*

As discussed above, health decision-making is bound up, to some extent, in the assessment of relative risk in the available actions. There is little work on how parents see risk in relation to feeding their children but for some health decisions, like vaccinations, the risks are more immediate and identifiable compared to food and health links which are both distant in time scales and complex in causation. When making decisions on child vaccinations, parents have been shown to look for the worst-case scenarios and consider the risks, with those who are most concerned consulting the widest range of sources for information (Senier, 2008; Wilson et al., 2008). Furthermore, Petts and Niemeyer (2004) found that media focus on health risk does not result in uncritical acceptance of the information but it does raise anxiety levels in those to whom the issue in question is relevant. In addition, Frewer (2004) shows that risk awareness impacts on risk management, which can have negative consequences. This is echoed by the work of Menon et al. (2002) who found those who have the greatest awareness of all the potential risks of relevance to them are more likely to consider themselves or a member of their family to be at risk. This work shows that awareness of risk is not necessarily going to assuage anxiety if parents feel they are unable to make necessary changes or decision that would reduce the risks.

Awareness of risks is only one element of engaging with and negotiating public health messages. It is important that messages individuals are exposed to are appropriately understood, with individual health literacy being central to both interpretation and understanding. Whilst it can be argued that messages must be simplified as much as possible to overcome issues of low health literacy (Zarcadoolas, 2011), over simplification or over generalisation of messages can result in a lack of clarity or obscuring of the message's nuance (Mazor et al., 2010).

Mazor et al. (2010) found that over generalisation of messages regarding cancer risk resulted in individuals over estimating their cancer risk. It is also the case that simple messages may be remembered but if they are not backed with possible actions, they will have no impact on public health. Molster et al. (2009) found that 82% of the women in their study knew that folic acid was important in pregnancy but far fewer were aware of the dietary sources of folic acid, rendering their knowledge of little practical use.

Class, taste and distinction

Some of the discussion above has highlighted the class based social norms that exist around feeding children. Central to the understanding of class, in relation to food, is the work of Pierre Bourdieu and in particular his work *Distinction: A Social Critique of the Judgement of Taste* (1984). Bourdieu (1984) introduces the notion of habitus, through which individuals adopt practices which can be understood as ‘lifestyles’, built on taste for what’s available to them. Habitus is a set of dispositions through which individuals make sense of, critique and operate in the world (Wacquant, 2008). Habitus is ‘necessity internalized and converted into a disposition that generates meaningful practices and meaning-giving perceptions’ (Bourdieu, 1984: 170). Practices are further constrained by the access to and accrual of social, economic and cultural capital and the field in which they take place. Fields are the areas of life, for example; employment, education, motherhood, in which practices take place and it is the interaction between the habitus, capital and field that determine practices and through which tastes are formed. Taste then functions as a symbol of social position, status and distinction (Williams, 1995). Bourdieu goes on to describe these class-based differences as ‘the opposition between the tastes of luxury (or freedom) and the tastes of necessity’ (Bourdieu, 1984:177). Importantly

for Bourdieu, taste was as much about distaste for the taste of others. Definitions of taste are made by those with symbolic power, gained through acquisition of cultural capital, which allows middle class definitions of taste to be considered the norm and through which the social norms of feeding children are defined. Skeggs (1997) further argues that a central feature of being working class is the lack of alternatives, leaving working class women unable to construct distance from necessity, from which they could construct distinction. In later work, she goes on to consider the importance of the judgement of taste, which she argues is always moral, situated in consumer culture and encountered daily (Skeggs, 2004). Skeggs (1997) also considers the ways that class-based divisions are further drawn along the lines of respectability, which focus on housewifery and mothering skills whereby respectability is categorised and judged. Through this process, those who are single parents or on benefits are considered in some ways as undeserving, which in turn enables the middle classes to focus on the behaviour of those they are judging rather than consider the circumstances in which they live (Skeggs, 2004). In relation to feeding families, therefore, moral judgements are made on the decision-making of individuals rather than through consideration of the wider structural issues that they may face.

Vincent (2010) sees all aspects of mothering as influenced by class as she says: 'mothering is one example of a site in which class is realised and reproduced, with those who do not conform to the normative ideal at risk of being exposed as morally insufficient' (Vincent, 2010:118). Risk of being seen in any way deficient drives mothers to present themselves as good mothers in relation to their food decision-making. In relation to feeding families, Backett-Milburn et al. (2010) argue that working class parents saw food as less important in their 'hierarchies of

worries', with middle class parents giving food higher priority. The parents in their study had teenage children and arguably they had more issues (including schooling and socialising) to worry about, which could be a reason for the perceived unimportance of food for some parents. Researchers must also look beyond the face value articulation of concerns if they want to understand parents' views on feeding their children. This is demonstrated by Coveney (2005) who found working class parents referred to food in pragmatic and functional ways compared to middle class parents, who demonstrated a more scientific and nutritionally informed understanding of food (demonstrated by their use of technical language). These differences do not necessarily show different classes of parents view the importance of food differently, or indeed want different feeding outcomes, only that their articulation of understanding differed.

Conclusions

There is a large literature on the complex ways food is woven into the fabric of our everyday lives on both a conscious and subconscious level. There is no space to detail this literature in this chapter but much of the work underpins understanding of the complexities of food and eating (see for example: Lévi-Strauss, 1966; Douglas, 1975; Fischler, 1980; 1988; Rozin, 1976; Falk 1991, 1994). Accepting that decision-making regarding food on a general level is complex, I have concentrated on literature that examines food within families and the ways that food provisioning contends with a complex set of needs and requirements encompassing taste, economic constraints, family composition, time, skills and social norms. In order to try and understand some of these factors I have looked to the work of a number of theorists to show that food work encompasses complexities which can be understood through looking at the ways the theories intersect.

Bourdieu's (1984) work on class can help in the understanding of food choice through his understanding of the oppositional tastes of luxury and the tastes of necessity where choice can be used to symbolise material separation from 'necessity' or class distinction. Class remains relevant but feeding children is done within a societal context that also has an impact on mothers, therefore, class is only one element that helps in the understanding of mothers' feeding decision-making. I have argued that we live in a neoliberal society, which has increasingly focused on the need for individuals to take responsibility for their own health and, as mothers, the health of their children. Peterson and Lupton (1996:12) call this the 'new public health' which they claim relies on individuals paying attention to their 'lifestyle'. To do the 'right thing', however, requires individuals to know what the 'right thing' is, which, increasingly, has come to mean reliance on experts to give that information. Dietary knowledge, both for oneself and for others whom you feed, has been the focus of much research but the ways that mothers have experienced expert knowledge (and the power it exerts) has not been studied. Foucault's (1988) work on the crucial links between power and knowledge is helpful in understanding how experts are given legitimacy and the ways that power is exerted (Rose and Miller, 1992).

Mothers also exist in social contexts through which their actions are judged by themselves and by others. There is a great deal of literature on the ideal of motherhood from Sharon Hay's (1976) work on 'intensive mothering' to more recent work on the need for mothers to keep up to date with scientific developments to enhance their child's life chances (Ristovski-Slijepcovic, 2012). The development of such requirements can be seen alongside the rise of what has been termed the risk society by Beck (1992) and Giddens (1991). Their work also looks to the importance

of expert knowledge and the desire to make judgements on risk. For mothers, risk is less about immediate food borne harm, although that is a consideration, but more about moral risk of not doing ‘the right thing’ (Murphy, 1999; 2003). Murphy’s work (1999; 2000; 2003; 2008) has focussed on feeding children in their first year and less work has focussed on the moral risks of not complying with feeding imperatives for pre-school children. The exception to this is research specifically on childhood obesity where mothers feel strongly the burden of responsibility (Pagannini et al., 2009; Jones et al., 2011).

Understanding how mothers view and react to information and advice on feeding their children requires consideration of the ways that the three theories of governmentality (Foucault, 1988, 1991), risk (Beck, 1992; Giddens, 1991) and taste (Bourdieu, 1984) intersect. Decision-making relating to feeding children is an ongoing endeavour, which mothers negotiate daily taking account of their and others’ preferences, knowledge and priorities. Central to this decision-making remains the moral risk of doing the ‘right’ thing. Murphy’s body of work (1999; 2000; 2003; 2008) has shown the salience of moral risk in mothers’ decision-making on whether or not to breastfeed and this thesis shows that the salience of moral risk continues past milk feeding. The risk thesis therefore encompasses both this moral risk alongside more practical risks (for example salmonella in eggs or having children removed into care). By considering the ways in which moral risk intersects with mothers’ engagement with information and advice to influence their feeding decisions, this thesis makes an original contribution to knowledge.

I have outlined the reasons why the state is interested in the food we eat, particularly as the evidence of the links between nutrition and disease show the impact of diet at the population and individual level (Lang et al., 2009). I have

shown that policies have moved increasingly towards individual action, which I have argued is in line with a general tendency towards a neoliberal society that puts the market and choices at the centre of public policy (Peterson and Lupton, 1996). The family has increasingly become the site for intervention as policies produced over the last ten years have focused ever more on early intervention, arguing that it is important to lay the correct foundations to enable the development of healthy citizens for the future (DOH, 2010b). Although these policies have given some consideration to key influences on dietary choice, including inequalities, they have focused heavily on the belief that information and knowledge lie at the heart of decision-making.

This study will bring together elements from the literature on class, risk, maternal responsibility and knowledge, focussing on where they intersect, diverge and conflict, to investigate mothers' experience of, and decision making around, feeding their children.

Chapter 2: Research Methods

In this chapter, I will consider the theoretical underpinning of my research and how that relates to the aims and questions. Furthermore, I will detail the methodology and methods I have used, explaining why they are the most appropriate in this context. Details of how I accessed my sample, including recruitment challenges and sample characteristics will be shown. The process of data analysis will be discussed along with some discussion of the presentation of my results. I will also outline ethical considerations and discuss my own reflexivity and where I, as researcher, sit within the research process.

Research aim

My research investigates how mothers negotiate good motherhood through feeding their children. To do so it will consider how mothers use, prioritise and privilege information and advice on feeding their children and what impact this has on their experiences as a mother. Rather than be concerned with finding out what they feed their children and how they follow the information and advice they are given, the study is concerned with how mothers engage with information and advice, how it impacts on their behaviour, how they assimilate new information and advice with long term knowledge and how feeding their children impacts on their views of themselves as mothers. The study investigates these issues through an analysis of the discourses mothers use around feeding children considering both the practical and emotional elements of these discourses.

Methodology

In trying to consider how information and advice impacts on the daily lives of mothers a qualitative research design is most appropriate. Rather than being interested in how many or which sources of information and advice are used I am interested in the decision-making which women employ both consciously and subconsciously. In order to understand some of these processes a qualitative approach is required to unpack the decisions and views that mothers make around feeding their children.

I will follow a constructionist ontological approach, taking the view that there is no one social truth which exists and is waiting to be discovered, rather that social interaction constructs social phenomena (Pottter, 1996). Further consideration must also be given to the epistemological assumptions which influence the way that data are both generated and understood. In seeking to investigate how the social world, in this instance related to mothers' experiences feeding their children, is understood, interpreted and experienced the research adopts an interpretive stance (Mason, 1996). Interpretivism derives from the theoretical work of Max Weber who called for an 'interpretive understanding of social action' (Weber, 1947:88 quoted in Bryman, 2008:15). In taking this position social scientists must look to understand the subjective meaning of both the behaviour and social actions of individuals (Bryman, 2008). Researchers working within this paradigm assign meaning to human actions but in order to do so must access the 'common-sense thinking' of participants in order to understand their social reality (Schutz, 1979). It is crucial, therefore, that in

producing and analysing data the researcher is sensitive to the social context in which the data are generated (Mason, 1996).

Methods

A qualitative research design is appropriate to research adopting an interpretive epistemological position, as I am interested in the subjective views of mothers who are engaged in the day-to-day realities of feeding their families, and children in particular. In order to find out about these realities, interviewing provides a method of producing empirical data through the process of engaging mothers in talk about their lives (Holstein and Gubrium, 2003). Ruiz (2009) points to the ways that our western society extensively uses verbal communication to convey meaning and he claims that it is through such discourse that the social world can be understood, whilst Holstein and Gubrium (1997) further argue that interviews provide a way for researchers to undertake social investigation.

For some, interviews are considered a means of uncovering the truth, which requires a passive, neutral interviewer (Legard et al., 2003), whereas I took a more active approach which reflects my epistemological position. As Holstein and Gubrium (2003) state:

Interviewing provides a way of generating empirical data about the social world by asking people to talk about their lives (Holstein and Gubrium, 2003:67).

Furthermore, qualitative interviewing allows the researcher to ‘explore the points of view of our research subjects’ (Miller and Glasner, 1997:100). Whilst accepting that interviews are interactions between the interviewer and the interviewee, rather than

naturally occurring conversations, the type of interaction is influenced by the degree to which interviews are structured. Totally unstructured interviews, which might be described as most like natural conversations, can be achieved with just one question to start the process and allowing interaction to flow from that point (Bryman, 2008). However, as Bryman (2008) argues such a tool is more suited to research that is more general in focus or that is aiming to understand more general attributes or beliefs of a group of individuals. My research was focussing on specific issues around how expert advice is used and made sense of in feeding children and as such, semi-structured interviewing was more effective.

Debates around whether a researcher should belong to the same social and cultural group as the interviewee are not new in social research. Miller and Glasner (1997) take the view that social differentiation between the interviewer and interviewee allows the interviewee to be the expert regarding the topic in question, which is a position they consider particularly beneficial in circumstances when the interviewer would normally be in a more authoritative social position. This debate leads to consideration of the extent an interviewer discloses their personal circumstances to research participants. Some attributes, for example sex of interviewer, are clear to participants, as is age group, to some extent, but the interviewer's status as a mother (or not) is not apparent to interviewees. I made the decision to answer truthfully any questions that were asked of me regarding my position as a mother but not to state it upfront or use my status in framing questions. As it happened, during all the interviews I conducted I was only asked once whether I had children. I established myself as a 'non-expert' who was interested in the participant's views on feeding their children and, as such, my status as a mother appeared to be of little interest therefore importance.

In addition to individual, semi-structured interviews, I undertook mini focus groups and paired interviews. Focus groups can be used to look deeper into the social context of a group's understanding of an issue, focussing on how and why they have particular views rather than focusing on the views themselves (Kitzinger, 1994). Barbour (2007) considers the use of focus groups to be particularly useful in studying the collective sense a group has of a particular subject, focussing on the interactions between members of a group and how, as member of this group, they discuss a specific subject. She also argues that they can be a useful tool for reaching otherwise recalcitrant participants who may be happier to participate in research with others, rather than be interviewed alone (Barbour, 2007). The use of focus groups has often been associated with market research, where it is important to recruit individuals with no pre-existing connections with one another. In qualitative social research, however, the use of pre-existing groups can add to the research. Kitzinger, for example, found using such groups in her research on the processing and understanding of media messages on AIDS, allowed her to access "fragments of interactions which approximated 'naturally occurring' data (such as might be collected by participant observation)" (Kitzinger, 1994:105). This is not to say that focus groups are like naturally occurring interactions, as the researcher constructs them, and the topics under discussion are guided by the research agenda. However, bringing together friendship groups for research can add to the depth of the research findings, as the participants can relate discussion to their shared everyday experiences, and can challenge each other when beliefs or actions espoused by one individual in the group are known to be contradictory to other group members (Kitzinger, 1994). This also allows issues, which may appear contradictory, to be explored, as people can, and do, hold two or more views on topics for example in

relating to food. Using friendship groups allows exploration of why these views are put into practice variously in different contexts.

Focus groups usually comprise 6-8 people brought together at the same time in one venue. I wanted to recruit mothers of pre-school children, and this could have given rise to potential childcare issues for those who were otherwise willing to attend. I was not in the position to provide childcare, or to financially reimburse women for their childcare costs, but I did not want to lose the dynamic element of interviewing friendship groups. Therefore, I decided to conduct paired interviews or mini focus groups, including up to five friends. By restricting the group size, I felt that there would be more opportunity to interview the women in the home of one of the group, or in a play space where the children could be accommodated without external care, without losing the dynamic element of interviewing friends together.

Research shows that women remain the family member who most often takes on responsibility for food purchasing, preparation and feeding children (Stapleton and Keenan, 2009; James et al., 2009; Wilk, 2010; De Vault, 1991; Henson et al., 1998; Graham, 1993). Furthermore, studies and interventions focusing on family food issues, where recruitment was open to either parent, show that the greatest proportion of participants have been mothers; regardless of whether the study was interview, active participation or postal survey (Skafida, 2013; Backett-Milburn et al., 2010; Berg et al., 2013; Watt and Rees, 2012). In addition, much of the current UK policy focus on the family targets women; as the gatekeepers to the family and the children upon whose lives policy makers wish to have an impact (Lister, 2006; Greet et al., 2009; DOH, 2010b; Madden and Chamberlain, 2010). As research shows, family feeding remains highly gendered (see: Stapleton and Keenan, 2009; James et al., 2009; Wilk, 2010 and discussion in Chapter 1), therefore, I decided to focus on

mothers for my study. By focusing on mothers, I do not intend to privilege mothers' decision-making roles but I do acknowledge that women make the bulk of food decisions in relation to young children. Accepting the gendered nature of care giving and making the decision to focus this study on women does not represent acceptance that the role of family feeding, particularly in relation to infants and children, is 'women's work'. However, in practice, it most often is.

Having made the decision to focus on mothers of pre-school children I then had to decide on the specific age group of children in whose feeding I was interested. Current government advice on feeding infants advocates exclusive milk (breast) feeding until the baby reaches about six months, after which other foods should be introduced, with the aim of reducing dependence on milk and achieving mixed feeding by the age of one year (DOH, 2010b). The period of milk feeding has been the focus of a great deal of research, to try and understand decision-making around breast or formula feeding (Murphy, 1999; Andrews and Knaak, 2013), and interventions to try and increase breastfeeding duration (Renfrew, 2012; Malchau et al., 2013; Lumbiganon et al., 2011; McQueen et al., 2011). The introduction of solid food into the diet has also been researched extensively, again, looking at decision-making (Anderson et al., 2001; Alder et al., 2004; Heinig et al., 2006) and parents' (mostly mothers') knowledge about, and understanding of, weaning (Hudson et al., 2005; Jones et al., 2011; McLeod et al., 2011). I decided that I would concentrate my study on mothers of young children who were over one year of age but not enrolled in school. Currently in the UK children must be enrolled in school the term after their 5th birthday (www.gov.uk/school-attendance-absence/overview) but, in practice, children start school in the September of the school year in which they will turn five. By recruiting 'mothers of pre-school children', I would effectively be

talking to mothers with children ranging between one and four years old.

Furthermore, by using the child's age as a recruitment criterion I would recruit a wide age range of mothers. I did not want to restrict my recruitment to first time mothers; rather, I wanted to include women who had two or more children, to enable consideration of the effects of having more than one child on mothers' views of information and advice on feeding them. Furthermore, I wanted to investigate whether they had noticed changes in information and advice between subsequent children, as well as the impact that a subsequent child(ren) had had on attitudes towards, and practices around, food and feeding.

Social class has been shown to have an impact on patterns of food consumption (Germov, 2008; McLeod et al., 2011; Murcott, 2002; Backett-Milburn et al., 2010) and it has also been shown to influence the prioritisation of developing healthy food preferences as a way to ensure future health (Backett-Milburn et al., 2010). It was important, therefore, to recruit mothers from different social backgrounds to be able to consider differences in experiences of mothers from different class backgrounds. Lawler (2005) argues for the continued relevance of social class in research analysis as she contends that social class remains central to identity and culture. Gillies (2005) considers the continued relevance of categorising individuals as middle and working class as she states:

This simple categorisation may overlay a greater complexity, but it allows analysis of the real effects of class as a set of systemized social relationships with powerful material consequences (Gillies, 2005:842).

For this research, I have used income as a crude measure of social class whilst acknowledging that social class is more complex than occupation or income alone (Lawler, 2005).

Taking account of the above criteria, I employed a purposive sampling strategy to allow maximum variation, which led to the range of mothers interviewed. In addition to the research interviews, I kept a research diary during my fieldwork period. I used the research diary to note down additional information immediately after interviews that I thought may be useful during my analysis, or to help me remember the context of interviews, including practical issues that arose.

The Interviews

A participant information sheet was produced which outlined in detail the purpose of the project and what was required of the participant should they agree to take part in the project (Appendix I). If a mother agreed to be interviewed, I gave her a copy of the information sheet for her to read. The sheet had all my contact details, should she have wanted to contact me to change the appointment or ask further questions before the interview. At the time of the interview, I talked to each mother about the project, ensured she had read and possessed a copy of the information sheet, and asked her to sign a consent form (Appendix II). The consent form also outlined my responsibilities as a researcher and I too signed the form. I made it clear to all the mothers who participated in the research that they could withdraw from the process at any point and that they were free to disclose as much or as little as they wished, including not talking about issues about which they felt uncomfortable. None of the participants withdrew from the process and there were no instances where I was aware that the interview touched on topics they did not want to discuss.

I also asked the participants to complete a household questionnaire prior to the interview. The questionnaire included questions on household composition, income, education level and age (see Appendix III). I assured respondents that all information disclosed on the questionnaire or during the interview would be confidential and that they should not feel obliged to answer any of the questions. I also explained that any real names and names of places, which were mentioned in the interview, would be changed, further protecting the interviewees' identity. Only one respondent did not complete the questionnaire and in that instance I had emailed the questionnaire having forgotten to take it to the interview, therefore, it was not necessarily that she felt uncomfortable responding. The question on income was the question most often incomplete, omitted by five respondents with three women stating they did not want to answer and a further one who did not know her household income. Income is highly personal as it is linked to both taxation and benefits, with income perhaps being seen as too personal to disclose to a stranger, even when anonymity has been promised.

Having decided to take a semi-structured approach to the interviews, I began each interview with a general question 'What is it like, feeding your son/daughter?' The aim of the general question was to allow participants to focus on whichever aspects of feeding their children that they wanted to. The remainder of the interview was guided by my interview schedule (shown in Appendix IV) with the order of the interview shaped by the interviewee. The interview schedule questions were used as prompts, where necessary, to ensure that all areas of interest were discussed.

All of the interviews were digitally recorded (with explicit prior permission), and transcribed verbatim. The use of the digital recorder allowed the conversation to flow more freely without interruption to take notes. I made notes to remind myself to

go back to an interesting topic but these were aide memoires to me and did not disrupt the interview. In total, I achieved 29 interviews with 38 mothers in a mix of individual interview, paired interviews and mini groups, as shown in Table 1.

Table 1: Interviews

Interview type	Number	Number of participants
Individual interview	23	23
Paired interview	4	8
Mini focus group	2	7
Total	29	38

I achieved a mix of first time mothers and mothers of more than one child as well as a mix of mothers of different ages and social class (based on income as a proxy for class), as shown in Table 2. Full demographic details of my sample are shown in Appendix V.

Table 2: Sample characteristics

Demographic category		Number
Number of children	1st time mother	18
	2+ children	20
Mother's age	25 years or under	14
	Over 25 years	24
Household income level (including benefit but before tax)	Under £200 per week	10
	£200 but less than £600	9
	£600 but less than £1000	5
	£1000 +	9
	Did not know/prefer not to say	5

The interviews lasted an average of one hour and six minutes and ranged in length from twenty-seven minutes to one hour and forty-one minutes. Following the interview, I transcribed the discussion and returned the transcripts to the participants along with a card thanking them for taking the time to participate in my research. I did this for two reasons, firstly to allow participants to feel ownership of their discussion, and secondly, to allow them the opportunity to remove anything that they no longer wished included or to add anything that they had forgotten. Individual

participants were asked if they would prefer the transcript returned by email or post. Where a hard copy was requested, I enclosed a stamped addressed envelope to allow the participant to annotate the transcript and return, to me, the amended version. None of the posted transcripts elicited a response. A number of the recipients returned emails to say they were happy with what I had transcribed. One participant requested the removal of a reference to her mother in law and one was unhappy about the way her spoken talk lacked grammatical correctness. On that occasion, I explained that I had transcribed the interview verbatim, including grammatical inconsistencies, and ensured her that all the interviews, and indeed all spoken conversations, were similarly inconsistent. Once this was explained, she made no changes to the transcript and was happy for the data to be used in my analysis.

Recruitment: issues and challenges

Ethnic origin and identity have been shown to impact food choice, through taste, nutrition beliefs, cultural habits and tradition to name a few (Caplan, 1997; Carrus et al., 2011). With an in-depth study of the type I undertook, it would not have been possible to select participants on the basis of ethnicity; rather I recruited mothers if they met the other recruitment criteria and asked them to identify their ethnicity on the household questionnaire I asked each to complete. Relatively early on in the study I undertook an interview with a woman from India who initially agreed to be interviewed with her friend. On the day, her friend did not attend the interview and the interviewee's level of English was not sufficient to conduct a full in-depth interview. Although some interesting data were generated, and the general questions were answered, it was not possible to delve deeper into her understandings of some issues or to elicit her deeper feelings on issues around food and feeding. From that point, I was more cognisant of the level of English potential participants

possessed. This was particularly important in one of the children's centres where the majority of the attendees at one playgroup had English as a second language and I was aware in talking to the women that some were not fully able to comprehend my questions. Without the aid of a translator, I did not recruit women whose level of English would hamper the flow of conversation in the interview. As a result, the vast majority of my respondents identified themselves as white British (31/38) although one of these women had come from Poland twenty years ago. Of the remaining seven women, three were white other (2 from Ukraine and one from Israel), one from India, one from Pakistan, one from Malaysia and one mixed black and white Caribbean.

As stated above, ethnicity influences food choice through taste, habit, beliefs and tradition. All respondents talked of the impact their upbringing had on their current views, beliefs and attitudes towards food and how their traditions shaped their decision-making when feeding their own children. This was as true for white respondents as those from minority ethnic backgrounds. Ethnicity intersected with age and social class in the ways that the mothers in this study regarded food and feeding their children. Although it was clear that mothers from minority ethnic groups drew on their food traditions they did so in a way that was mirrored by the white respondents who also talked of tradition. On the basis of the sample size and the analysis, which showed ethnicity to impact all women's food choices, it was more insightful to focus on the salience of class.

In setting out my recruitment strategy, I did not set about recruiting mothers individually or in groups. Instead, I wanted to recruit mothers and allow them to decide whether they wanted to talk to me on their own or with one or more friend. I produced a flyer (Appendix VI) which outlined my project, requirements of

participants and my contact details. From previous experience, I know that once an individual agrees to participate in a project it is most likely that an interview will be achieved if it can be scheduled within a few days of the initial contact. For that reason, I decided to contact potential recruitment sites sequentially, thereby allowing me time to schedule interviews as soon as possible after making contact with mothers. The first contact I made was with a workplace nursery catering for around eighty children over the age of one. The manager agreed to hand out my flyers to every parent in the nursery. I was contacted by five mothers all of whom agreed to participate and were successfully interviewed. I was not surprised by the low response rate from parents at the nursery, as receiving unsolicited written material asking for volunteers is not the most effective recruitment strategy, but the experience was a useful starting point. I then contacted a number of children's centres in the Midlands to ask if I could attend their 'Stay and Play' sessions. 'Stay and play' sessions, offered by the majority of children's centres, are informal 'drop-in' sessions where children are given access to play equipment, with some form of organised activity which involves parents and children. Parents then have the opportunity to meet one another for a chat, join in activities if they want to, and can access staff at the centre for help with any issues relating to their children, if they want to do so.

The first children's centre I visited allowed me to talk to mothers during their informal sessions. I chatted to the mothers to explain my research project, what I would need from any participants and handed out my information leaflets. I found that talking to the mothers about the project was a successful strategy in gaining their interest and agreement to participate. I also discovered very early on in my recruitment efforts that it was important to emphasise that I was not going to be

asking mothers what they fed their children or asking them to keep any records of feeding. Some of the mothers I initially approached were reluctant to talk to me until I made it very clear I was only going to be asking them what their views and opinions were, and how they felt about information, advice and feeding their children. Once mothers were satisfied that I would not be monitoring the food intake of them or their children, they were much happier to agree to participate in my research. Directly monitoring food intake is more personal, invasive and can ultimately be used to judge mothers against an ideal. Assuring mothers that this was not my intention allayed concerns. As the interviews progressed many of the mothers chose to disclose specific details about what they fed their children but thinking that was the aim of my research was an initial barrier to participation. As I mentioned above, I wanted to make sure I could interview potential participants within a few days of recruitment to reduce the possibility of drop out. Therefore, at each session attended I only recruited the number of mothers I could interview within the following week.

Initially I was happy to recruit any mother with a child in the target age group and as I progressed, I refined my strategy to target different children's centres in order to access mothers who were younger and from different social backgrounds. To help facilitate this I contacted a larger children's centre in an area of the Midlands with greater levels of deprivation. Having made initial contact I visited the centre to explain my project to the centre manager and the staff who organise the 'stay and play' sessions. The staff were very supportive and suggested a number of groups to attend. I attended two groups at the second children's centre; one was a general group and the other was for mothers under the age of 25 years. I made a number of contacts at the general group, but the mothers in that group were less willing to talk

to me about my project or to agree to participate, and I only achieved one interview from that group. One of the main issues with this group was the number of mothers who did not have English as a first language, which became clear as I approached the mothers. I also found out from staff members that many were asylum seekers who may have felt under scrutiny already, therefore, were less willing to talk with a stranger. The young mothers' group was much smaller and run by two very enthusiastic members of staff. The staff members suggested I came to a few sessions where I helped with a number of activities and participated in the general group discussions. The staff introduced me to the group as a university student who was interested in issues around mothers and food and I attended three of their weekly sessions. The Children's Centre staff suggested the strategy of getting to know the group before I introduced my study or asked if anyone would be willing to participate. They were experienced in introducing new people into the group and felt that participation would be greater if I was someone familiar. Staff members felt I should be aware of some personal issues that a few members of the group were dealing with, to allow me to be sensitive to their situation when recruiting mothers from the group. I made sure I spoke to all of the group members and invited all to participate in the study should they want to whilst being sensitive to those I knew had many issues they were dealing with at the time. This strategy led to interviews with three of the mothers in the group; another two mothers initially agreed but did not arrange a time or cancelled their appointment.

I made contact with one further informal playgroup, which met in a local church hall, and through them, with another smaller group, which met in a community room in a local council estate. With these groups, I employed the

strategy of attending the group, chatting to the mothers then introducing my project and asking if anyone was interested in participating.

Towards the end of my fieldwork period, I concentrated on recruiting younger mothers (under 25 years old) as I had spoken to relatively few young mothers. The first children's centre I had visited ran a small group for young mothers. I contacted the centre worker who ran this group and was able to arrange a mini focus group at the children's centre. Through this group, I met another leader who ran a group for young mothers who met outside of the children's centre. She agreed to ask if I could visit this group and the young women agreed to my attending their next session. This led to three individual interviews and one of the mothers agreed to help me set up a mini focus group at the hostel for young mothers where she lived; this focus group took place.

My access was aided by enthusiastic children's centre staff, who were interested in my research project, and by my attending numerous play sessions, over a number of weeks, to chat informally to mothers and recruit them face to face. Overall, the dropout rate, once initial contact was made, was very low. However, I learned through experience, that I needed to make contact with a mother the day before the scheduled interview, to remind them of the time and to check on the place; this was the case for individual interviews, paired interviews and mini focus groups. This strategy meant I only had two further participant dropouts, both of whom no longer felt they had the time and did not wish to re-arrange the interview.

To help with recruitment, I was flexible over the time and place of the interview and whether mothers wished to be interviewed alone, with a friend or with a group of friends. The majority of the mothers opted for me to interview them on

their own, in their own home. A further group of interviews took place the individual's place of work; one group was interviewed in the children's centre; another group was interviewed in their hostel and two were interviewed in cafes.

Analysis

Having set out the ontological and epistemological assumptions underpinning my research I had to choose a method of analysis that reflected this position. Discourse analysis stems from an interpretive epistemology which sees 'discourse' as a way of making sense of the constructed world around us (Ruiz, 2009; Phillips and Hardy, 2002). Discourse analysis is concerned with the construction of social life through talk (Gill, 2000) and, as such, rejects the notion that there is a truth waiting to be uncovered by research. Instead, discourse analysis is seen as an interpretation that considers discourse central to the construction of social life (Wood & Kroger, 2000; Gill, 2000). Central to this is the use of language, which, rather than being used to describe the world in neutral terms, constructs social practices through 'talk and texts' (Potter, 1996; Gill, 1996). Phillips and Hardy (2002) further argue that discourse analysis allows the researcher to consider the way social reality is produced and, in particular, the relationship between knowledge and power, focusing on their disciplinary effects.

In undertaking discourse analysis, Potter (1996) argues for the use of interviews to allow for a number of themes to be explored with a number of participants, which would not be possible if naturally occurring data were to be sought. Of central importance within the context of the interview is the way in which language is used and constructed, taking account of the social world inhabited by the participants whose language will be full of meaning (Gill, 1996; 2000). The questions that

discourse analysis asks of the data are around, why is it that the participants are saying what they do, in the moment they do so, whilst considering the context in which the participants live. Philips and Hardy (2002) argue that uncovering the production of social reality through interpreting language is where discourse analysis is a powerful research tool. The analysis requires reflexivity from the researcher on the co-production of the data through the interaction of the researcher and participant. Further, paying attention to the ways in which the terminology and practice of conducting the 'interview' also shapes the results.

I transcribed the interviews as soon as possible after they were conducted, both to help me in remembering the interview itself, and to enable me to return the interviews to the respondent whilst the interview remained fresh. This enabled the respondents to make changes to the interview should they want and to add anything they had subsequently thought of. The process of transcribing the interviews as they were conducted meant I started the data analysis process as I was carrying out subsequent interviews. During the first few interviews, ideas about themes and issues which would be useful to further explore were noted in my research diary and, where appropriate, were raised in subsequent interviews.

The interview data were subsequently transferred into Nvivo 9, a qualitative data analysis software programme, which aided me in collecting, sorting and analysing my data. Each transcript was read and re-read and each section of text coded. Through the coding of transcripts major themes emerged from the data, which led to the framing of the data chapters of my thesis. Within the major data codes, the data were further coded into minor themes, which allowed more detailed interrogation of the data. The process of doing so allowed me to see cross cutting themes and connections between data. The data coding was an iterative process; as new themes

emerged, it was necessary to return to previous transcripts to code for these additional themes. Thus, the richness of the data could be drawn out as I became more familiar with each interview transcript, and the ways in which the discourses related to each other, across themes, emerged.

Reflexivity

In thinking reflexively about the process of conducting research in general and this research in particular, I need to reflect on my position within the research process. My interest in feeding young children in general, and in the particular role of information and advice, grew from a job working for a national health education body as research specialist for diet and nutrition. Through that role I observed that often our programmes did not take enough notice of the context of mothers' lives when developing materials to 'help' them 'comply' with nutrition guidelines. I then went on to have children of my own, and this furthered my interest as experience widens one's understanding of the myriad of competing and conflicting claims on mothers' time and priorities, not to mention the child's own subjectivity. Although passionate about instilling the principles of good nutrition in my own family, I am also aware of the conflict this can create, and therefore, of the need to be flexible.

I positioned myself as a 'non-expert' on food and nutrition, and key gatekeepers within the Children's Centres and playgroups I visited introduced me, which helped establish myself as a sympathetic and legitimate person. It was important that I would not be seen as someone who would be judging the women I interviewed on their feeding practices. As participants knew I was conducting research as part of a university degree, they were aware of my educational status, and my physical appearance identifies me as a middle-aged white woman. As my most

successful recruiting strategy was through personal contact with potential participants, I can only assume that my age, ethnicity and educational position, although different to those of many of my respondents, did not deter those who agreed to participate.

Some of the younger women constantly answered their mobile phones without acknowledgement to its disruptive effect. Although I did not disclose my own status as a mother, having teenage children allowed me to reflect on generational differences in social mores. My own children similarly text while conversing with others and are often surprised by older people's reaction to that behaviour as is both commonplace and natural for them. Personal experience thus allowed me to be unsurprised by such behaviour and therefore be un-reactive towards it.

Interview challenges

Children were present on many occasions and it was important to allow for that in the interview process. Interviews were sometimes interrupted if a child had to be put to bed or lifted from a nap and there was some amount of interaction between the children and myself during the interviews. Despite these interruptions, which made the transcriptions difficult on some occasions owing to background noise, the interviews were not hampered by the flow of family life. Victoria O'Key et al. (2009) recounted many difficulties recruiting and conducting research, around eating and food, in lower income households, often feeling unnerved in participants' homes. I had the opposite experience as all the women in my study welcomed me into their homes to talk about their lives. Many offered me refreshments and were

willing to adhere to my requests to switch off televisions or music that was loud and potentially disruptive to the interview.

Ethical concerns

As a researcher at the University of Warwick I conducted my research according to the guidelines set out in the University's ethics statement: <http://www2.warwick.ac.uk/services/rss/services/ethics/statement/guidance/#> and also in line with the British Sociological Society's research ethics: <http://www.britisoc.co.uk/equality/Statement+Ethical+Practice.htm>.

Ethical consideration should be made with regard to four basic principles: doing no harm; gaining informed consent; respecting privacy and eschewing deception (Bryman, 2008). With regard to these principles the harm that could be caused to participants participating in this research would potentially be emotional harm or stress. Food and feeding can be emotive issues especially around feeding children and I did find some respondents became emotional during some areas of discussion. Recalling negative breastfeeding experiences was most likely to elicit a negative emotional response. That said I did not ask any of the women directly about milk feeding but it was an areas of discussion that was frequently raised by the participants themselves and one which, for many, remained emotionally raw. Initial feeding of babies lies at the heart of establishing oneself as a good mother and difficulties with breastfeeding remain highly emotive issues (Hays, 1996; Murphy, 1999, 2006). I had information on support groups for breastfeeding but this was not required as the women had all gone past this stage of mothering. Only one other mother became visibly upset during the interview and that was when she recalled a discussion during which she was told her child was overweight. In this instance the

respondent was being interviewed with a friend who gave her verbal reassurance and support. There was also one young mother who only recalled being given basic information on feeding her children and was wanting further support and advice. In this instance I emailed her details of department of health websites (Change4life, nhs choices), and reminded her that she could access help through the children's centre group worker, who had invited me to the young mums' group where we had initially met.

Consent is an important ethical consideration within any research project. I obtained written informed consent from each of the participants before any interviews were conducted as described above (see Appendix II). Each participant received a detailed outline of the aims and objectives of the research with their contribution, in terms of an interview, being clearly explained (see Appendix I). At the time of the interview I asked permission from participants to record the interview, reminding them that I would listen to the recordings and transcribe them verbatim. The participants were informed that during the process of transcription the interview would be anonymised but that direct quotes from the interview might be used in the future, either in my thesis and/or future publications. I assigned a pseudonym for each mother, making sure none of the names I used were the real names of any of my other participants. Within my thesis, quotes I have used name the mother (identified through her pseudonym) and note her age and number of children. These details are to position the women within my research. I have not revealed which children's centres I have used to recruit participants or the exact location of the research beyond placing it in the Midlands region of England. Given the number of women and children within the region I feel that this protects their anonymity as far as is possible. Reassurance was given to participants that data held

would be safeguarded through the use of password protected files and that original recordings would be destroyed after transcription. Participants were also informed that they were free to withdraw from the research at any time without having to give a reason for doing so. This is in line with the view that informed consent is not a one-off event but that participants have the right to change their mind at any time (University of Warwick Guidelines on Ethical Practice, 2011). Participants were also informed that they were free to answer only those questions they wish to and that participation does not imply they are compelled to answer all questions put to them. This particular point relates to the issue of privacy in that individuals are free to make decisions on disclosure at any point during the research process. To avoid any issues of deception the information potential participants received about the study explained the scope of the research, its purpose, and the potential uses to be made of data gathered during the research process.

Chapter 3: Understanding health in relation to a ‘healthy diet’

Exhortations to follow a ‘healthy diet’ which are advocated in health policy documents (DOH, 2010b; 2010c; 2011), and in information given specifically to mothers of young children during their early years, presumes that there is agreement on what health and a ‘healthy diet’ are. This presumption, therefore, ignores the many and competing definitions of health, including physical activity levels, sufficient sleep and having a relaxed attitude to food that mothers negotiate in making family food decisions. Research shows that mothers do not challenge the dominant discourse that claims health advantages, conveyed through a ‘healthy diet’, nor do they challenge the agenda that privileges the importance of health overall (O’Key and Hugh-Jones, 2010; Noble, 2007). Furthermore, mothers accept and articulate the links between health and diet both in the long and short term (Carmel et al., 2011; Wood et al., 2010; Crombie et al., 2008). Meanwhile responsibility for the provision of a healthy diet is also accepted by mothers (Boucier, 2003), who further believe they have the greatest impact on their children’s diet (Williams et al., 2011). This acceptance of responsibility for child health, coupled with acceptance of the dominant discourse of health, leaves mothers vulnerable to criticism should their child become ill or show signs of health issues for the future, for example being unfit or overweight. Therefore, mothers must negotiate definitions of health, along with versions of healthy eating, to be able to claim status as a ‘good’ mother.

Lupton (2012: 2) states that the family is the ‘pivotal site’ at which concepts of risk and governmentality intersect. Understanding and defining health can be understood through consideration of these concepts. Taking Foucault’s notion of governmentality, which exhorts individuals to behave as responsible citizens

(through assessment of the self and disciplining oneself to act in appropriate ways), it is possible to consider how mothers consider and act upon imperatives to maximise health (Foucault, 1977; 1991). In our current neoliberal society, mothers must act not only for themselves but must care for their children to enable themselves to be responsible citizens (Lupton, 2012). Power is also an important factor in the ability (or not) of mothers to act to maximise health. Foucault saw power as a disciplinary technique, exercised through simple instruments of observation, judgement and normalising (Foucault, 1977). Central to this production of power is ‘knowledge’, which is realised through ‘experts’ who are essential in articulating government priorities (in this case what children should be fed) and in connecting with individuals to help them act appropriately (Rose and Miller, 1992; Nettleton, 1997). Knowledge of government recommendations for maximising health, whilst crucial, is only one element in the understanding or conceptualisation of what represents health in relation to family food. This is where the second element of Lupton’s (2012) thesis on the pivotal site of the family comes into play. Lupton (2012) argues that concepts of risk are also important in the ways that parents position children central in family decision-making. Linking back to the risk theorists Beck (1991) and Giddens (1992), discussed fully in Chapter 1, who assert that we are living in a risk society, which has grown up in the period of later modernity. Of importance to mothers’ concepts of health, as they relate to healthy eating, are the perceived risks of not adhering to government guidelines. Giddens (1991) argues that one of the main drivers for individuals is the desire to control the future through assessing risk. With this desire comes the need to balance risk and opportunity in a way that will enable choices over which risks to pay attention to and which to push aside as unlikely events (Giddens, 1991). Mothers are required to make such assessment on

behalf of their children, looking at both current and future health outcomes associated with making particular health choices. Beck (1992) considered these choices pervasive with individuals making risk assessment as part of their normalised activities. As risk assessment becomes more scientific it also becomes more removed from ordinary understanding, therefore, requires experts to help with both understanding and assessment (Beck, 1992). Beck and Giddens talk of risk relating to choices over actions with concomitant outcomes, which could be detrimental to the health and wellbeing of individuals. There is a further aspect of risk, which impacts on all parents but arguably on mothers more directly. This is the moral risk associated with parenting practices, through which parents are expected to provide for the physical health of their children along with their mental health and cognitive development (Hays, 1996; Murphy, 1999; 2003; Wall, 2010). Mothers are thus entreated to take account of risk, both physical and cognitive, assessing expert advice to negotiate feeding their families.

The focus of this chapter is on issues of health, considering how health, in relation to diet, is defined and prioritised by mothers. The translation of mothers' understanding of healthy eating into providing food for their families is considered along with mothers' views on health both now and in the future. All of this is set in the broader context of negotiating good mothering, taking account of everyday constraints relating to feeding families. This discussion will lead on to consideration of the role of the expert, and in particular what constitutes expertise in relation to feeding families, which will be presented in Chapter 4. Consideration of health and expertise will then feed into Chapters 5 and 6 which will consider the particular discursive roles of 'good' food and 'bad' food and the importance of the family meal.

The Importance of Diet

Most mothers viewed their child's diet as one of the most important things that they had to concern themselves with in raising their children. The importance of diet was clearly linked in mothers' minds to wider health issues, as articulated by Joanne:

It's really important, it's just part of, it's how they stay happy and healthy isn't it? I mean if that's not right then they'll start going wrong in like they won't have the energy to play or do anything right will they? So yeah it's really important. (Joanne, age 28, 2 children)

Many mothers linked diet, health and happiness and articulated concerns for the future. They also talked of concerns over the amount of exercise their children were getting, their general development, behaviour and amount of sleep. Overall diet was seen as more important on account of its links to future health and a worry that their child would become overweight. Some mothers specifically linked how they were feeding their young children now to how they would eat in the future:

It's for the rest of their lives. You've got to lay down the blueprint now so that they'll have healthy habits in the future. (Claire, age 40, one child)

It's [diet] the building blocks for life. (Lesley, age 41, one child)

Claire and Lesley uses the terms 'blueprint' and 'building blocks' to indicate the scientific, deterministic way they regard the establishment of dietary patterns. This

discourse links to the current rhetoric, spearheaded by Iain Duncan-Smith, that claims early intervention is necessary to solve many social issues from poor attainment at school to eating a healthy diet (Allen and Duncan-Smith, 2008). The other future event mothers wanted to avoid was overweight. Diet was considered important in the avoidance of this future possibility:

I don't want her just eating junk and then becoming overweight or something like that. So I think it's quite important, just I don't want her to be ill, I don't want her to be overweight. (Judith, age 21, one child)

It's important 'cause obviously I said I don't want them to be overweight, stuff like that, but it's not a major thing. (Nikki, age 27, 2 children)

Ill health and overweight are seen as inextricably linked by Judith whereas Nikki does not want the possible future of overweight children but is less concerned as she does not see the issue to be affecting them now. Both mothers are linking diet to the risk of overweight even though neither had any concerns over their children's weights at the time of the interview. Both are also reflecting the powerful social discourse which claims obesity, especially childhood obesity, is at epidemic proportions therefore both are indicating awareness of the risk to any child and by showing this awareness reflects well on them as attentive mothers. Only one mother dismissed the notion of healthy eating altogether:

I ate junk when I was younger and I'm alright. All this healthy eating's a load of crap to be honest with you. If you get some veg, you get some fruit and veg, fair enough but I don't need to go

overboard, make sure he has every single thing, every day sort of thing like some mums do. (Rachel, age 19, one child)

Rachel is claiming not to care about healthy eating, yet she mentions fruit and vegetables as important dietary elements. This shows that she wants to display knowledge of what is important (fruit and vegetables) which in turn allows her to be seen as a good mother. Having initially dismissed the notion of 'healthy eating' as 'crap' she then displays her own notion of what is important in feeding her child and by so doing concurs with others that fruit and vegetables are crucial to dietary health.

Healthy Diet in Balance

Having indicated that diet is important to health, most mothers then went on to define a healthy diet as one that was 'balanced'. Indeed, mothers used healthy diet and balanced diet interchangeably. The concept of balance took many forms, none of which would be recognised as balance by nutritionists, whose definition of a balanced diet would encompass food groups provided in balance with one another as shown in the eat-well plate⁴. Mothers most often talked of balance as including fresh foods, in balance with other foods, such as processed foods, convenience foods or sweet treats and snacks. Talking of balance being achieved not just within one eating event or meal but, most commonly, over a day or week.

Some days I'll sit there and I'll think has he actually had a balanced diet today, um, you know, but sort of I would say four days out of five we hopefully get it right. (Lesley, aged 41, one child)

⁴The eatwell plate is a visual representation of how different foods make up a healthy balanced diet therefore eating foods in the proportions shown on the plate would mean adults and children (over 5 years) would get all their required nutrients
<http://www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx>

Having talked of the importance of diet and health, Lesley is showing not only that achieving a health diet it is something she actively thinks about but also that, achieving her ideal requires thought and is not easy to achieve, even for caring, thoughtful mothers like herself. Fresh fruit and vegetables play a pivotal role in mothers' articulation of a 'healthy' or 'balanced' diet and were talked of by most mothers as being the key to achieving their version of a healthy, balanced diet.

In general over a week or something they are eating, like yesterday she didn't eat much of her tea she had a bit of vegetables but I think the meat was a bit even though it was chopped small it was a bit chewy I suppose um but afterwards I thought well I'm not going to make a big fuss about it however hard I try she's not going to eat it so I'm not going to try and then she had a whole pear and half an apple and some yoghurt so I was, well she'll have something else tomorrow. (Karen, aged 39, 2 children)

Like Lesley, Karen talks of the whole week as her reference point for a healthy diet. In her description of her daughter's eating, Karen is very specific about the fruits and vegetables consumed. These represent health, therefore if there is some consumption of fruits and vegetables mothers have very little to worry about. A lack of consumption of these foods is represented as more problematic than consumption of less desirable foods as Judith explains:

She'll eat chocolate and then she'll want more, more, more and some days she'll have a lot and I just think, you know, it's bad because obviously she hasn't had any fruit or veg to top it up, to

make it a little bit better so I do worry a little bit. (Judith, age 21, one child)

Again fruit and vegetables represents rescue for the diet, if children were eating fruits and vegetables then their mothers felt better about their diet. All the mothers I spoke to listed the particular fruits and vegetables that their children were willing to eat but equally importantly, that they enjoyed. This position is illustrated by the way Vicky describes her daughter's eating habits:

In the morning she'll probably have toast with jam on then she'll have strawberries and grapes or plums or apples, she'll always have fruit in the morning, um, for lunch she'll always, well I always put stuff like tomatoes, grapes, stuff like that in her lunch box and then for dinner she always has vegetables or, you know, she does have a balanced diet so. (Vicky, age 22, one child)

Vicky's version of balance emphasises fruits and vegetables at every meal but there is no mention of other food groups in this description. Mothers' emphasis on fruits and vegetables derives from a desire to present themselves as knowledgeable about what constitutes health in the diet as well as using the presence of fruits and vegetables to cancel out less desirable foods, as shown by Judith. Fruits and vegetables (particularly fresh) in the diet have been heavily emphasised in public health campaigns relating to diet, most notably the Five-a-day Campaign launched in 2003 (Capacci and Mazzocchi, 2011), therefore it is not surprising that the mothers I talked to all mentioned the importance of feeding their children fruits and vegetables. The mothers in this study echo Grunert et al.'s (2010) study, which showed that

knowledge of the health benefits of fruits and vegetables, along with messages to increase consumption, are high amongst the general population.

Whilst the idea of fruit and vegetables negating the effects of less healthy elements of the diet and in themselves creating balance was talked of by most of the mothers, there were varying ways that mothers dealt with the issue of sweet treats and snacks. Some mothers took a hard line position on sweet foods and talked of avoiding them as far as possible, falling short of imposing a total ban. Banning foods was potentially going to cause more problems as children grew. Mary recalled a family she knew growing up:

..their kids weren't allowed anything other than what was considered as kind of natural food and they kind of had a weird take on food, they weren't allowed anything that was, they weren't allowed cakes, biscuits, even if it was homemade, they weren't allowed anything that was seen as a treat. And those children craved that in such large quantities that when their parents weren't watching would gorge on this stuff. (Mary, age unknown, 5 children)

Many of these mothers whilst avoiding an all out ban were happy to impose strict rules on their children as Amy explains:

He knows that if we're having chocolate for example, we'll say 'no that's Mummy and Papa's chocolate but you can have something else' and he would have something, his little biscuit or non sweet thing or fruit. (Amy, age 35, one child)

Amy is creating a distinction between adult and children's food with her categorisation, which she considers reasonable, as she wants to avoid his consumption of sugar. Other mothers considered sweet treats as something that was almost a right for children to experience and certainly something they would have little control over, as Vicky says: 'I would like her not to eat anything bad but, um, I suppose I can't help her from being a child' (Vicky, age 22, one child). Sweet foods and snacks played distinct discursive roles for these groups of mothers. Those who set up strict boundaries around sweet foods and snacks and who were prepared to impose rules were more likely to be older and middle class. Whereas those who saw sweet foods and snacks as an inevitable part of childhood, and one which they did not want to totally deny their children, but over which they also felt they had less control, were younger and working class.

Providing a healthy diet, however it is defined, requires work. As experts define the composition of a 'healthy diet' for all members of the population, mothers are required to interpret this for their own families and ensure that their children are provided with foods which will enhance their health both now and in the future. This task is constant and gives rise to anxiety as mothers are caught between the ethical formations of themselves and their children. Parents must respect the rights of their children, including respecting their choices and preferences, yet must also fulfil their obligations to provide a healthy diet (Coveney, 2006). Coveney (2006) further argues that these, often opposing, obligations leave parents (in practice mothers) unable to 'do the right thing' all the time, leading to anxiety. Many mothers spoke of the everyday grind of making sure that their child had 'eaten properly', as externally defined, and ensuring that they were getting all that they

required in terms of nutrients to keep them healthy, active and to a lesser extent happy. Moreover, they spoke of the anxiety caused when things did not go well.

Many mothers described feeling anxious to feed their children a 'healthy diet'. For some, this was one of the many ideals of motherhood into which feeding must fit, as illustrated by Hayley and Geraldine who talk of the ideal of healthy eating and eating together but how these ideals can get sidelined:

Hayley: Um, it doesn't come completely naturally to me giving my children healthy food day in and day out, which in my head, that's what I want to do. But I don't know, I kind of go a bit on autopilot really, um, it's always at the wrong time of the day, it's always a crush, kind of getting in dinner after clubs before going to bed. I like my kids to go to bed really early, so sometimes it's sacrificed, so yeah. I think I find it generally quite stressful, 'cause they're not brilliant eaters, um, and it's like, it's like I can't, not can't be bother to fight the battle but I kind of, I don't feel ready to fight that battle to get them to be good eaters or well behaved at the table. So it's all a bit carnage at dinner time really.

Carol: And what about you, how do you find it?

Geraldine: Well similarly it's very stressful. I find the kind of time, sort of the time of getting something healthy prepared for them in the evening hard. We try and eat together, my husband gets home early enough luckily for us to eat together, so we try and do that, but sometimes that's just too stressful to try and achieve really, and

similarly they're not the most adventurous eaters. (Hayley, age 35,
3 children, Geraldine, age 37, 3 children)

Competing priorities, for example, taking children to clubs after school and getting them to bed early, both of which can also be seen as 'good' mothering practices, are in tension with feeding ideals. By stating that feeding her children healthy food does not come 'naturally', Hayley is showing that she has to make a concerted effort to feed her children in the way she feels she ought to in order to claim 'good' motherhood. For Geraldine, eating together as a family in the evening is of prime importance, and it is an ideal that she returns to throughout her interview, although achieving this ideal also requires effort. This discourse displays the ideals these mothers have adopted with regard to family feeding and how achieving them requires a great deal of effort, which they describe as both stressful and a constant cause for concern. Such ideals derive from the dominant social discourses of the importance of feeding children according to nutrition guidelines, along with enhancing their learning through extracurricular activities.

Worrying about doing the right thing in terms of providing a 'healthy' or a 'balanced' diet was more often talked about by the older mothers. However, this was not exclusively the case. Emily is a young single mother with limited income, and she too feels the importance of making sure that her daughters are eating what she sees as a 'balanced' diet. She mentioned that she worried about one of her daughter's eating habits and when asked what worried her she went on to explain:

You know, is she getting enough protein, is she getting enough
calcium, you know, is she going to have brittle bones or, you
know, is she going to get colds all the time with her immune

system, is she getting the right vitamins, is she getting enough vitamin C, is she getting enough vitamin B is she getting any...

(Emily, aged 26, 2 children)

Here Emily talks of more than just what her daughter may be getting in terms of nutrients but also of the consequences of not having a balanced diet for her future health. For other mothers the wider issues, as picked up by Emily, are a source of constant uncertainty and a cause for remaining vigilant. What you do not know can also be a source of anxiety as Catherine describes:

Just things like that even on *older daughter* you don't know what they are allergic to until they have an allergic reaction or you don't know you know if there was a chilli in something necessarily that you've ordered until it arrives and you know just constant, it's a constant thing. (Catherine, aged 41, 2 children)

Catherine talks about both seemingly innocuous issues, the presence of a chilli in a food order, and potentially serious issues, allergic reactions, in the same sentence. By coupling these issues, which appear to be on completely different scale, in the same way, Catherine is showing her anxiety and vigilance around everything is, as she says, 'constant'. Risks in modern society are often hidden (like toxins in food or air pollution), requiring experts to make them known. Anxiety arises from the knowledge that, as a mother, you cannot know all the risks, both immediate and long term, that exist.

Feeding children is not a static thing that mothers consider they have solved, rather it is an ever changing continuum where children are described as going through phases sometimes good and sometimes bad. Maternal anxiety changes along

with these phases and mothers often reflected on how stressed or anxious they felt when they recalled a stage or phase that one of their children had experienced. If they were in a more stable phase at the time of the interview, it allowed them to realise how stressful a previous stage had been. This cyclical reality for many mothers meant that when things were going well anxiety was pushed to the back of their minds, then something would happen that would bring it front of mind again. A number of mothers expressed this:

I end up in cycles, I go for quite long periods thinking 'it's fine, everything's fine' I'm quite relaxed about it all and then I'll have a bit of time thinking 'oh maybe they're not having a healthy enough diet' and it will normally be something that triggers it like so at the moment *daughter's* got this issue with constipation so now I've become really worried about the fact that maybe I'm not giving her the right kind of diet and she's not drinking enough and whatever that's causing it um, so then probably for a while now I'll be worried and be spending a lot of time really thinking about it and but then I'll go through a long period thinking well this is how we eat and that's fine I'm quite happy with that. It varies. (Geraldine, age 37, 3 children)

Um, I think I worry always (*laughs*), you know, when she eats well it's fine, but if something happens, she doesn't eat, 'oh it's my cooking maybe or it is something she doesn't like, or maybe, she doesn't feel well, or' so something like this. So always, you can find some, you know, case to worry. (Katya, age 37, one child)

The way these mothers talk of their anxieties show how powerfully they feel the expectation on them to provide their children with a healthy diet and how acutely they feel the responsibility. When children are not eating as expected mothers see this as a problem they must solve and constantly question what they are doing. There is a sense of keeping on top of children's eating and not letting things slip. Katya's list of possible explanations for any change in her daughter's eating, shows the extent she feels responsibility. These are powerful emotional responses, which result from these mothers' desire to claim an ethical self as good mother. In feeding their children, mothers have to negotiate versions of health derived from the experts, which they have interpreted to fit in with their own routines and with what they can feasibly achieve.

Health as happiness and enjoyment

Although the discourse of health as balance was dominant amongst the mothers I spoke to, some mothers talked of the importance of happiness and enjoyment in food consumption. These mothers concurred with the discourse of healthy eating as balance but saw happiness and pleasure as equally important. The mothers who talked of pleasure and happiness were expressing the importance of food as social, in addition to its role in health.

Their health, their enjoyment of food because I always think that food should be fun, food needs to be fun sometimes to encourage children to eat, experimenting with different foods, different textures, different tastes, um, but it's mainly that they're happy and healthy with what they're eating and what they're getting. (Emily, age 26, 2 children)

As long as they're happy in how they're eating and things like that. So like when he was eating earlier, he was all smiling and he was engaged and he was, you could tell he was having a really good time and he loves having like his banana and spreading it around his face, 'didn't you, you had lots of fun'. (Joanne, age 28, 2 children)

For these mothers, health and happiness are connected but more importantly, this represents enjoyment as these mothers would not want to feed their children food which they did not enjoy, even if it was beneficial to their health. This discourse speaks to the importance for mothers in taking account of their child's taste and preferences, which must be negotiated alongside mothers' interpretation of healthy eating. These positions allude to the importance of children's agency. James and Prout (1996) suggest that the acknowledgement of children's agency has increased since the 1980s. Much of the work on children's agency tried to separate the child from the family yet as James and Prout (1996) argue family provides children with important social and emotional connections to everyday life. In later work, James and James (2006) consider the role of the family as being both responsible for children's socialisation and concurrently the key mechanism for controlling children through the surveillance of family life. Mothers therefore have a pivotal role in monitoring their children yet also developing autonomy and negotiating their food preferences alongside other family considerations.

Influence of upbringing on definitions of health through food

As Anne Murcott (1995) argues, food decision-making is complex, deep rooted and shaped by each decision maker's social and cultural context. Sobal and

Bisogni (2009) looked to model food choice decision-making and suggested that decision-making is linked to life course. They suggest specific transitions and turning points (for example getting married, having children or experiencing ill health) lead to changes in food choices and are influenced along the way by past experiences (Sobal and Bisogni, 2009). Gillespie and Johnson-Askey (2009) also considered the multiplicity of factors influencing family food decision-making and suggested that past experiences, coupled with current environments, shape family food structures. They also suggest that changes in environment or the family unit can be the catalyst to changing food routines (Gillespie and Johnson-Askey, 2009). The mothers in this study talked of the ways that their past influenced their current family food decision-making. Past experiences fell into one of three discursive positions: those who privileged their past food experiences, those who wanted to make a complete break from the past, and those who wanted to retain elements of their past food landscape but who wanted to update the past according to new knowledge and experience. These positions highlight the importance of understanding past influences and the ways in which the past reflects on current family food habits and priorities, as found in the work of Gillespie and Johnson-Askey (2009) and Sobal and Bisogni (2009).

One group of mothers saw their upbringing as the way forward and for them their past experiences guided their food choices both now and into the future. Lorna, a single mother of three children, cooked with her mother every weekend to get food into the freezer. She also talked of her mother coming round most evenings to eat dinner, although she lived elsewhere. Lorna talked of her mother's influence on her choice of foods for her daughters and how she was very involved in food preparation:

I mean my Mum, well yeah my Mum sort of comes up, on a
 Sunday, as I say we cook for the week. And my Mum does the

cooking that I don't know how to cook properly..... because my Mum and Dad both worked she was always adamant we would always sit down and have dinner, evening meal, no matter what time it was you would have an evening meal with the family.

(Lorna, age 25, 3 children)

The past is represented in current food choices and in the social aspect of eating as a family. Lorna further wants to replicate the importance of the family meal, which is another way of displaying good mothering through tapping into the wider discourse on the family and will be considered further in Chapter 6. Nina, who came from a very traditional Asian family, also cooked following a tradition that she had been brought up with:

To be honest I haven't cooked a lot at my Mum's house when I wasn't married. But when my Mum used to cook I used to be there, I knew what she was putting in, how much and when. I am standing by her and talking to her I knew what was supposed to go in and when and that's how I learned.(Nina, age 23, 2 children)

Nina, who learned by example, had responsibility for the cooking for all her household which comprises her husband, two children, parents in law and an elderly relative. She used traditional recipes which she adapted to suit her new circumstances, including reducing the amount of chilli to suit her father in law's taste. Nina's husband and son like some elements of 'British' food including pizza and chips which she also has to negotiate. Retaining traditional influences allowed for small adaptations as explained by Emma:

I try and cook different things and um, keep things a bit interesting so we're not eating the same things all the time. But yeah, I suppose a lot of it, my Mum always made spaghetti bolognaise, my husband doesn't like that, so I make lasagne. Roast dinner, I mean that's something that my Mum did every Sunday without fail and I do it every Sunday without fail, um, you know, try and have a bit of variety but we have a roast every Sunday so yeah I suppose a lot of it is influenced. (Emma, age 35, 3 children)

Emma talked of making changes to suit her husband and to try to keep everyone interested by varying what she cooked. There was little talk of her preferences in how she described what she chose to prepare. The 'Sunday roast' was mentioned by a number of mothers and remains an iconic meal, the significance of which links to tradition, the social aspect of eating together and the labour and care that mothers are willing to expend in putting that particular meal together. The mothers who adopted this discursive position were generally working class. The work of Bourdieu (1984) on class and distinction, as discussed fully in Chapter 1, can be used to understand the position of these mothers. With less economic capital for experimentation, they have retained tried and tested traditions in their food preparation. It could also be argued that they have retained the tastes they grew up with which have not been challenged by moving into situations where the foods eaten are significantly different, as was the case for other mothers in the study. Changes that were made could be regarded as small adaptations, less chilli or making mince into lasagne rather than spaghetti bolognaise, all of which were talked of in terms of keeping other family members satisfied rather than privileging themselves.

The second position saw mothers wanting to make a break from the past. Women taking this position considered the diet they were brought up on either to be lacking nutritionally, or to be restrictive, narrow or simply unpalatable. Zoe, a young mother of one child, had lived with her mother and stepfather and really wanted to break with her past dietary habits:

When I was growing up we lived off greasy food, fatty food, chips, burgers, deep fried sausages, deep fried burgers, you know, the cheapest, cheapest food. As well it wasn't even nice, it was just cheap, um, but whenever I went, 'cause my mum and my dad didn't live together they broke up, whenever I went to my dad's I'd have really nice proper home cooked meals and everything. ...Yeah I lived with my mum and she had a really controlling husband who would control all the money and he bought everything cheap, the cheapest of cheapest, nasty stuff. So yeah, that's why now I won't touch anything that's really cheap I won't have fat food, I cannot have greasy food it's all got to be grilled just because I used to be physically sick. (Zoe, age 19, one child)

Food was used as a controlling mechanism, therefore the break from the past is as much about Zoe's experiences of living with a domineering, controlling stepfather as it is about food. Particular foods, therefore, reminded her of a time which was unpleasant, and showed the powerful links between food and experiences for many people. Although talking of how particular food reminded her of the past she was also showing that she does not want her daughter to have the same experiences. Other mothers deliberately wanted to make a change from the past to give their children a different experience of food and eating. Vicky, a single mother with one

daughter, talked of her experience as a teenager cooking for herself and not having the experiences of other friends:

We used to have, I don't remember young, young but I know that when we were teenagers all we did was, we came home, we got a microwave meal out of the freezer and put it in the microwave. And I mean, none of us are particularly big, it's.... like most of my friends, their, you know, their mums as a teenager taught them how to cook. I was never taught how to cook and so I never really knew, um, I think that also affects my shopping because I never know what to buy, um. Like it's, if there's a recipe in front of me then at least I've got the ingredients that I know I need to buy. (Vicky, age 22, one child)

Vicky is negotiating her vision of good motherhood through wanting to give her daughter a different experience with food. Leaving children, even teenagers, to heat frozen dinners represents a lack of care and lack of concern over health and nutrition. Wanting to pass on cooking knowledge is also part of being a good mother as good mothers involve their children in food preparation now and look to the future in preparing their children to produce healthy food when they leave home. The women who talked of making a complete change from the past were all young and working class. They described a particular version of eating that they wanted to create which differed from that they experienced growing up, indicating increased understanding of the links between health and diet or particularly poor nutritional circumstances in the past.

The third position included women who wanted to make some changes to their diet whilst retaining elements of their past. This group of women saw some of the traditions, for example home cooked meals from scratch, as things they wanted to retain but they wanted to incorporate what they considered advances in knowledge, on both the psychology of eating and nutrition science. One of the specific changes talked about by a number of mothers was the prescription to leave a clean plate. A number of mothers recall being forced to eat all that was given but consider this both counter-productive to getting a child to eat and also detrimental to allowing children to realise their own capacity and stop when they are full:

I would never force her 'oh you should leave your plate clean, empty' like my parents did to me. I think it is quite wrong and, you know, so I don't think I will do this to my child. I got very good advice from a nutritionist who came to the children's centre, which I mentioned, and she said: 'a baby feeds their appetite, so if a baby wants to eat, they will ask you about food. They will look for food and, you know, if they don't want it, they just don't want it. Nothing to do with your cooking, or anything else. So if a baby is hungry it will eat'. So, it works with my daughter. (Katya, age 37, one child)

Mothers like Katya want their children to develop their own autonomy relating to food consumption, something that they perceive their parents would not have condoned. A number of mothers talked of encouraging their child's autonomy but this strategy holds risks, as they want autonomy only if the autonomous choices are the 'right choices'. Another commonly cited change from childhood was incorporating a wider range of foods into their diet. Moving away from home or

meeting their partner were the most often mentioned catalysts for widening their own food repertoire:

When I went to University and everyone else went for a curry, so I went along 'cause I wanted to fit in and then I thought 'actually this is quite nice'. And I met my husband when I was twenty three, and he just eats everything. He's ex-army, and he'd go on these, sort of, you know, he's had worm omelettes and, like locusts and he's had all the random extreme kinds of foods on survival courses so, um, that's helped me broaden my horizons a bit in terms of food. And then, you know, because of that I've become much more into food.

(Sofia, age 39, one child)

Sofia's parents, who had both died, were from the Ukraine and she described her diet when growing up as very plain and stodgy. Sofia wanted to acknowledge the labour her mother exerted, cooked from scratch, and this was something she wanted to retain, albeit cooking different types of foods. Talking of her husband's food experiences emphasised her lack of exposure to new and different foods growing up, highlighting her current strategy to expose her son to as many foods as possible. Amy grew up in Malaysia and was, in her opinion, very fussy as a child. She articulated strategies that she wanted to employ which she hoped would avoid this developing in her son, and was proud to say that he had a very wide and varied diet at the time of the interview. She did, however, talk then of her own mother's influence in locating family eating central to family life:

Yeah, I mean it's her influence really, from her, you know, feeding children is important. When we were growing up she always made

sure that we had one cooked, I mean when we were teenagers I remember but I can't remember when we were younger what we did, but she always made sure we always, we had one cooked meal, home-cooked meal a day because she said 'ah I can't control what you eat when you are out and about at school or college, whatever we were on, but, you know, we'll make sure that when you have dinner you can have something nutritious, once a day, not eating rubbish', um, and I think that's always been sort of foremost.

(Amy, age 35, one child)

For Amy, family is central to her mother's legacy along with the emphasis on nutrition and the care and labour shown through 'home-cooked' meals. All emphasise the caring good mother displayed through food. The mothers who talked of retaining the caring and family focussed elements of their upbringing were middle classed. They all emphasised how they would differ from their parents from widening the foods available, like Sofia, to giving their child more autonomy, like Katya. Showing differentiation was important to these mothers, as they wanted to demonstrate that they were up to date on current healthy eating guidelines and were aware of recommended parenting practices, including not forcing children to clean their plate. These mothers were all in the fortunate position of being able to make choices over what to feed their children through their access to the capital to allow such choice making.

The discourses linking the mothers I spoke to with their upbringing did not explicitly talk of definitions of health but showed through their talk of home cooked and family meals that there were ideals they wanted to replicate or instigate. Home cooked and family centred meals indicate caring mothers who are willing to put time

and effort into feeding their children and were powerfully present in all the mothers' accounts of what they wanted to replicate or avoid from their own upbringing. They were explicitly present in the accounts of middle class mothers who wanted to retain these elements from their past and equally explicitly absent from the accounts of the young mothers who described how they wanted a different way of feeding their children. Looking to the past was important for mothers in making decisions about how they wanted to negotiate good motherhood through food. Mothers were also aware of the impact of their current decisions on the future health of their children.

Healthy 'lifestyles' for the future

Looking to the future was important for many mothers as they discussed reasons for setting up rules and trying to pay attention to feeding their children a healthy diet. For some mothers, one of the main motivations for striving to provide a healthy diet for their children was to instil the importance of healthy eating as part of a healthy 'lifestyle'. They then expected their children to follow this 'lifestyle' once they were no longer living at home. One way mothers talked of reaching that goal was to instil 'norms' in their children or defaults so that the healthy choices would be made unthinkingly:

If the telly can be off the telly can be off. I'd prefer her to be playing with her toys or playing outside. We're not in very much, I prefer to go out and do things with her, to get out. Yeah so it gets into her, so it's the norm for her to be out and about so she doesn't think she has to be sat indoors watching telly. (Stef, age 20, one child)

I just want that she has a nice taste for food and in the future she will have these habits and, you know, you always come back to food, that you are familiar with, which you had in your childhood and, you know, you always feel happy about it. Doesn't matter what she eats so it's what she used to have so I think if she will have these habits of healthy good food it will help, it will be good for her now and in the future, you know, in general. (Katya, age 37, one child)

Stef linked her own television watching to previous weight issues so is equating this activity with being lazy and at risk of overweight which she doesn't want for her daughter. Both of these mothers are looking to future habits and giving themselves, as mothers, responsibility for establishing the right habits in their very young children. Both believe that setting patterns now will have future benefits. Some mothers, who equally saw the importance of establishing habits early, wanted to make the links between health and action explicit:

They're going to go to school, they're going to become adults, they've got to learn to make choices. They've got to understand why you can't have cake every time you go to the coffee shop, they've got to learn that we don't eat ice cream and pudding every day, that they're treats but why. We try very hard to explain to *older daughter* that you've got to look after your teeth and that's really important. I haven't talked to her about weight at all, that doesn't come into it really for us, it's about balance and keeping your body healthy. (Liz, age 36, 2 children)

Catherine: We certainly explain all the time the effect on, juice on her teeth when we are brushing her teeth and the fact she had chocolate today, she's got to brush her teeth and why she can't have juice at night and why she can only have like milk and em..

Carol: So one of your strategies already is to explain to her the health, (Catherine: yeah totally) so you do it on a health basis?

Catherine: Yeah and we have done for quite some time and she needs explanation, she won't have it otherwise. (Catherine, age 41, 2 children)

Liz and Catherine were among a few parents who mentioned dental health. Both mention using dental health as a way of limiting sugary foods and both preferred to talk to their daughters about their teeth rather than weight, which was the underlying reason behind both mothers wanting to limit their daughters' access to sugary snacks. Both emphasise health, choice, the future, and the need to give explanations. Explaining rule making to young children requires more effort but emphasises their agency and the parents' hope that this will instil acceptable decision-making in the future. In doing so mothers are aware that it is important not to demonise foods, especially those that you know your children like. Mothers therefore constantly balance their notion of healthy eating with their child's desires for foods that lie outside of this ideal. Those who wanted to restrict foods also felt it was important to explain to their children why they were doing so and why 'you can't live on cake' as Alena explains:

Well I think, um, I think I've already mentioned, the first thing was to try to expose them to lots of different foods. I am also trying to,

obviously, trying to develop his concept of healthy food but also not trying to say the other food is really, really bad. But it's difficult because he is only three and a half so he can't, kind of, conceptualize everything but I am trying to say that in small amounts it is okay. That a cake is not bad but, you know, obviously you can't live on cake every day because there are certain things that, you know, you need to sort of feed your body with. I suppose we are kind of developing the concept of kind of healthy ingredients as well. (Alena, age 44, one child)

Alena, like the mothers above, is trying to produce a child who will be an autonomous decision-maker by the time he reaches school age. Mother hope this will be achieved by equipping their children with the knowledge to make their own (or their mother's) choices and to choose healthy foods.

Some mothers talked very explicitly about concerns over their children's future weight. Older mothers, like Liz and Catherine (see above) obliquely talked about weight but specifically did not want to mention it to their children. The younger mothers were much more explicit in raising the issue of future weight problems. When asked if anything worried her about her daughter's diet Stef raised the issue of weight:

Um, I don't know I just like to know that she's got something good inside her, that she's going to maintain a healthy lifestyle and that she's not just going to, I mean a lot of the media these days is all kids are going obese and stuff. I mean, media is media. (Stef, age 20, one child)

Stef also linked weight to inactivity, as mentioned above, and although she tries to underplay her concerns by referring to the media as possibly over exaggerating the issue, it is clearly something of concern. In suggesting that kids are ‘going obese’, she is distancing herself from the responsibility of her daughter’s weight yet positioning herself responsible for her daughter’s ‘healthy lifestyle’. Additionally in stating ‘media is media’ she is both dismissing the issue as over emphasised yet also demonstrating that she is clearly concerned by her daughter’s future weight. Linking the current emphasis on overweight to the media was done by a few mothers including Sam who talked specifically of the extreme portrayal of weight issues in the media:

Oh, seen the state of half the people, not to be rude, but you know I don’t want them to be one of those people who are so unhealthy that they can’t even walk out their own doorway. They need to have extra large door frames. I have only ever seen it, I watched a programme *Big Body Squad*, well Jesus he can’t get off his wheelchair for one minute to walk through a door frame and get back into his wheelchair ‘cause he’s that overweight. I just think Jesus I don’t want them, if he keeps eating chicken nuggets and crap. (Sam, age 22, 2 children)

Whilst acknowledging media portrayals are extreme this discourse shows Sam is concerned about a possible future, which she links to poor diet. ‘Chicken nuggets and crap’ are symbols of ‘bad’ food, which Sam talks about as her son’s preferred foods. Although she was worrying about his food intake at the time of the interview, she also spoke of the importance of being active: ‘I know he’s not eating healthy but he’s very playful, he does a lot of stuff’. Being active is used as a proxy for health

and by talking of his levels of activity, Sam demonstrates some elements of good mothering. Only the younger, working class mothers explicitly talked of worrying that their child may become overweight in the future; although none were concerned about their child's weight at the time of the interview. Those who were older and middle class acknowledged the popular discourse, which emphasises childhood obesity but none talked of feeling concerned for their own children having talked of the ways in which current health and health for the future were being addressed by their specific actions and strategies over food choices.

Conclusions

This chapter has demonstrated the pertinence of the links between diet and health to mothers of pre-school children. Through examination of their discourses around the importance of health, the links between diet and health, the importance of food enjoyment, the influence of upbringing and their concerns for their children's future health, it has demonstrated mothers' awareness of the dominant discourse that links healthy diet to wider health outcomes. As found by O'Key and Hugh-Jones, (2010) and Noble (2007) these mothers did not challenge the importance of diet to health either now or for the future. Clearly articulating the importance of diet to health some, for example Catherine and Claire, considered the pre-school period as critical in establishing future eating patterns using phrases like 'blueprint' and 'building blocks' to emphasise what they saw as the deterministic role of food to health. Furthermore, mothers were willing to accept the responsibility for their children's diet and health as none dismissed its relevance or claimed that someone else should take responsibility. The two mothers who claimed it was their choice, as parents, to decide what to feed their children did not dismiss the discourse of health completely as they then talked of the importance of fruit and vegetables through

which they could claim good motherhood by providing essentials to health. By linking the enjoyment of food with health and happiness, some mothers were demonstrating a broader definition of health, which was less structured around recommended intake but which emphasised the importance of giving their children a wider appreciation of food, which they hoped, would help build a healthy relationship with food for the future.

Looking to the future was important for many mothers. However, there were differences between the discourses of younger, working class mothers and older, middle class mothers. The younger, working class mothers talked of concerns over the negative outcome of their children becoming overweight or obese whereas the older, middle class mothers talked far more of establishing norms and tastes which would ensure they made healthy choices in the future. These differences have commonalities in that all the mothers are considering the possible risks to health of a variety of outcomes, albeit one framed in negative terms and one in positive terms. Giddens (1991) considers the time of high modernity in which we live one where individuals must weigh up choices and make judgements based on risk. He argued that individuals engage in inevitable life planning whereby risks are assessed and actions planned to enable the individual to 'colonise the future for themselves' (Giddens, 1991: 125). Risks are inherently considered when looking to the future whether they are seen as something that can be planned for and avoided, as was the case for middle class mothers, or acknowledged as a threat over which one feels little control. The young mothers, who talked of concern over potential future weight gain, talked less of current strategies that they were employing to avoid this future outcome. Research which has considered the classed differences in parenting often suggests that middle class parents are more forward focussed, whilst working class

parents are more focussed on the present (Gillies, 2005; Vincent and Ball, 2007; Lareau, 2011). Both middle class and working class mothers in this study were forward focussed; although there were differences in how they saw the future for their children. Decision-making on which elements of health or diet should be the focus of mothers' attention relies on knowledge of the risks inherent in each possible strategy. Giddens (1991) saw the assessment of risk to be predicated on access to expertise, the need for which has grown out of the modernisation of society, creating ever more specialised knowledge. Expertise and the role of knowledge in health decision making will be presented in Chapter 4.

Chapter 4: Expertise

In Chapter 3, I presented the ways in which mothers conceptualise health, and how that conceptualisation relates to thinking on risk both now and in the future. Understanding of risk is required to make decisions about courses of action, including what foods to feed your children, but that decision-making is not made in a vacuum, instead it relies on knowledge and understanding of the options and the consequences of each course of action. Beck (1992) and Giddens (1991) both consider the role of knowledge in the understanding of risk. For Beck (1992) the risk society determines risks through science which in modern society has become fallible thereby leading to a situation where the claims of science are both necessary yet open to question. Such uncertainty leads to a loss of power in scientific knowledge and the need to make sense of competing or overlapping risk claims, all of which must be worked out individually. Giddens (1991) saw risk assessment as a fundamental part of life planning which individuals undertake in an attempt to ‘colonise the future’ (1991: 125), by which he meant they could make sense of and try to control future possibilities. Within his notion of life-planning individuals make choices, although such choice making is not done on the basis of equal access to all possibilities, with lack of options for some being experienced as burdensome. Furthermore, as modern institutions and technological development require ever more specialization individuals are lay people in respect of ever more areas of risk understanding. Giddens (1991) concludes that thinking about risk, whether or not that knowledge is acted upon, is inevitable in our modern risk society. Mothers must consider risks in relation to their own life planning, furthermore they must also be aware of and take responsibility for risks to their children. As discussed in Chapter 1 the continued gendered nature of care giving leaves mothers taking responsibility for

much of the risk planning relating to many areas of their children's lives, including eating.

Whilst risk theorists argue that assessment of risk is done by everyone, regardless of whether or not they act on that assessment, such assessment must be based on knowledge. In modern societies with ever more emphasis on scientific knowledge and specialisation, experts are required to impart knowledge to lay individuals about increasingly numerous areas of everyday life. In relation to food and eating experts are looked to for information on what constitutes an optimal diet and how best to achieve it. When scientific expertise was first considering issues of nutrition the focus was on the overindulgence of the richest in society, as seen through the work of the seventeenth century physician George Cheyne (Beardsworth and Keil, 1997). However, by the late industrial period, work by philanthropists, for example Joseph Rowntree, focussed attention on the dietary deficits of the working poor (Beardsworth and Keil, 1997), with new scientific discoveries at the centre of understanding about the role of diet. Pat Crotty has criticised the continued development of the discourse of nutrition according to scientific, authoritarian rules such that the population is considered 'sick' and in need of reform (Crotty, 1995). She sees the current development of public health, based on the scientific model, as a type of social control, whereby individuals are expected to conform to nutrition recommendations (Crotty, 1995). Coveney (2006) also considers the links between science (nutrition) and food choice stating: 'nutrition emerged as a concern for the population's health and welfare through a problematisation of life and labour' (Coveney, 2006:23). Whether it is viewed as social control or concern over health and welfare, it is evident that individuals are expected to look to experts for advice on what constitutes a diet for optimum health. Mothers must make decisions on

behalf of their children therefore, face greater scrutiny on that decision-making as children are not capable of making such choices for themselves. Mothers are given information and advice on feeding their children from milk feeding onwards and are expected to engage with that advice in some way.

Scrutiny over how mothers choose to feed their children is a powerful mechanism of governmentality which is a concept Foucault (1988) uses to explain the way in which power is exerted on individuals who in turn self regulate (see discussion of Foucault in Chapter 1). Of importance here is how power is exerted not as an external force, rather as a productive power through the idea of surveillance or a panopticon (also discussed in more detail in Chapter 1). In this way power is exercised continually through all levels of society and whereby discipline is a functional mechanism ensuring a ‘disciplinary society’ (Foucault, 1977).

Experts therefore assume an important role for mothers as they negotiate the feeding of their families. They are relied upon to impart nutritional knowledge but they also problematise feeding children. Furthermore, mothers will turn to experts to help them translate their worries, by finding solutions to their feeding problems. This chapter will explore how mothers are given, or seek, information on feeding their children and how they in turn interpret and engage with this material. It will discuss how mothers deal with information discursively: to what extent they use it to self-regulate, to ensure they are conforming to expert advice or to dismiss expert knowledge. It will also explore issues of risk as they relate to conforming to expectations.

Sources of information and advice

Looking first to the presentation of information and advice to mothers, all of the women I met were able to recall receiving information and advice on feeding their children. I had initially thought that ‘information’ and ‘advice’ would be qualitatively different things, whereby information would be regarded as neutral and less value laden, and advice would be considered as prescriptive and an imperative to follow, with concomitant emotional responses. However, the women in my study talked of information and advice almost interchangeably and only referred to them as being different when directly asked. It is possible that information is most often presented or given as advice; therefore, the two are seen very much interchangeably. For this reason I am going to write about information and advice together, as the mothers I engaged with talked of information and advice very much as part of the same process.

I was not primarily interested in milk feeding or the early weaning process; consequently, I tried to focus on issues that were affecting the mothers in my study in relation to feeding their children at the time of the interview. All but two of the mothers had children who were over one year old (the two mothers who only had a child under one year were included as they were part of a paired interview or mini group and were feeding their children a mixed diet). Milk feeding was spontaneously spoken about by many mothers, both in relation to problems they had encountered, and triumphs they wanted to retell. For many, this involved the health professionals encountered and the feelings they invoked, or their experience as a ‘good’ mother and I will consider these issues in more detail when discussing the role of the ‘expert’ and parenting issues. Nevertheless, I will discuss where the mothers went to

for information and advice, and set that in the context of whether or not they felt there was a need for information and advice on feeding their children.

Although we started discussing where they got current information and advice on what to feed their children, for the most part mothers wished to talk first about information they had received when weaning or moving on to mixed feeding. When prompted about information relating to what they were currently feeding their child or the family as a whole, the mothers spoke of a mix of what they described as instinct and sources. As weaning information was the first thing recalled and spontaneously reported, I discuss this first. The fact that the majority of mothers spontaneously talked about weaning information reflects the importance they gave to the developmental milestone of moving on from milk feeding. Furthermore, it is a period about which health professionals and online support websites focus, as do commercial food manufacturers. Mothers reported weaning as a time when they both sought information, and focussed heavily on what their children were eating, as they were trying to 'get it right'. The initial weaning period greatly influenced mothers' general feelings about feeding their children.

All mothers recalled receiving some information and advice relating to weaning, although a few required additional prompting to do so. Broadly, the mothers fell into one of two discursive positions with regard to sourcing information and advice on feeding their young children. Mothers either talked of getting information from a wide range of sources, which they actively assessed and then acted upon, or, they spoke of privileging their own mother's advice and their upbringing, regarding official sources of information with some degree of mistrust. Mothers in both discursive positions regarded their own instincts as mothers and

their uniquely knowledgeable situation, regarding their individual children, as lenses through which all other sources were viewed.

Mothers who described themselves as active information seekers were predominantly older, over thirty years of age, and were educated to degree level or equivalent. They were very proactive in seeking out information from a wide variety of sources and wanted to display their rigour in both seeking out information and using one source to corroborate what they had found in another. Two friends interviewed together easily recalled all the different sources of information they had used:

Hilary: First time I got mine from pamphlets, health visitors and, um, some DoH stuff.

Claire : The pack that they give you yeah,

Hilary: Yeah, and the big book, the Birth to Five book, um.

Claire: Books, yeah.

Hilary: I suppose the internet, yeah, books, I've looked on the internet this time as well... Oh and the bible, Annabel Karmel⁵

Clarie: Oh, Annabel Karmel.

Hilary: She was my bible a bit [laughs].

(Hilary, age 43, 2 children, Claire, age 40, one child)

In listing many and varied sources of advice these mothers are presenting themselves as discerning, hard working mothers, willing to expend a great deal of time and effort to access the knowledge they required. Part of the negotiation of good motherhood was, for them, through the time and labour expended. They also wanted

⁵ Annabel Karmel is a successful writer of books on infant and child feeding.

to present themselves as discriminating, whereby they would assess information sources and advice, then make informed choices over which they would accept, and which they would both question and reject.

Rejection of advice was not done without careful consideration. These mothers talked of conscious decision-making before they rejected current advice on a particular aspect of feeding. The advice which was most often questioned was the age at which specific foods could be introduced, including the introduction of peanuts. Although some mothers expressed their willingness to reject guidelines on weaning, they were very explicit in explaining why they had done so. They did not want to present themselves as feckless mothers who recklessly rejected expert opinion. Rather, they were discursively utilising their instincts as mothers as a claim to knowledge. These mothers were negotiating expertise by examining expert advice in the light of their own experience and knowledge.

Sheila: I'm always, I'm quite cynical as well about some of the advice because like the peanut thing, they put out one thing and a few years later they say actually that's not right. So I'm always a bit sort of, I kind of do my own research or use my own knowledge if you like, to say 'well do I agree with that or am I thinking that's just...'

Alison: I'm like that as well.

Carol: So what do you mean?

Alison: Well like with peanuts (Sheila: if it's something I think oh I don't..) if there is something, yeah, if I think there is a reason for it, like the honey, if it could give them something or I know, if like, when you're pregnant making sure (Sheila: like unpasteurised

cheese) yeah or salads that they are washed because they could have listeria, yeah I think that makes sense to me or um..

Karen: Whereas I do what I'm told (*all laugh*)(Sheila, age 39, 2 children, Alison, age 30s, 2 children, Karen, age 37, 2 children)

Giddens (1990) argues that contradictory or changing advice reduces confidence in scientific expertise and Beck(1992) sees that greater knowledge leads to greater uncertainty, further suggesting that those who have access to more information were more affected by the risks such information may suggest. He then goes on to suggest that individuals who are faced by modernization risks become alternative private experts to help them make decision on how to act (Beck, 1992). In the face of uncertainty, these mothers talked of seeking further knowledge through their own research to establish their own expertise, which they then mobilise to establish decision-making on feeding their children. The activities of knowledge seeking and establishing expertise help these mothers negotiate good motherhood in the face of uncertainty. One of the group, Karen, claimed to adhere to all expert advice; 'I actually gave *son* his first nuts when we went for a scan because I thought well I'll give him them in the hospital corridor so if anything happens (*all laugh*)' (Karen, age 37, two children). Karen saw her cautious approach as good mothering, having considered the possible outcomes, but her friends consider her approach as over cautious which is indicated by their reaction, laughter, at her noting both she does as she is told and recounting the particular incident of the nuts.

Another feeding issue, which elicited discussion over expertise, was baby-led weaning. Although this was not a case of accepting or rejecting advice per se, it is relevant here because the mothers either wanted more information on the subject or found themselves questioned by health professionals. Baby-led weaning is a term

coined by Gill Rapley, a British health visitor, who coupled her own experiences of child rearing with her experience as a health visitor to suggest an alternative way to introduce babies to mixed feeding. Whilst studying for a master's degree, Rapley observed that babies spontaneously reached for foods when they were ready, around 6 months. Her findings coincided with the change in official recommendations to wait until six months first by WHO (2002) and the UK government (DOH, 2003). Rapley wrote a guide to baby-led weaning (Rapley, 2008) and set up a website. Other baby-led weaning guides have been developed, but knowledge of baby-led weaning amongst health professionals and mothers is not universal. I asked all the mothers in this study whether they had heard of baby-led weaning with similarly mixed results. More of the mothers who talked discursively of being active information seekers reported hearing of, or having followed, baby-led weaning. Those who had adopted baby-led weaning also talked of mixed reactions and levels of support from health professionals. Some talked of receiving a great deal of support:

I had a friend who'd done it, um, and also I think it was just kind of, it was just something that the Sure Start Centres, which were a great support to me in the very beginning, just something that they kind of, I don't know, they don't push on you but it's just kind of there in the background. And it's just almost, not expected, but just that you follow that pattern. We went on a weaning class at the Sure Start Centre. (Lesley, age 41, one child)

Whereas others were encouraged but talked of feeling they knew more than the professionals:

They've [health visitors] said it's good to get them doing and that I should keep feeding him like that but they don't really understand baby led weaning...they've just dealt with I suppose well with their children with pureeing and things. (Joanne, age 28, 2 children)

Views on expertise for these mothers are influenced by their experience. For Joanne, expertise is bound up with an individual's personal experience whereas Lesley did not question the professional's own experience as she felt supported. Mothers who adopted baby-led weaning often used online information: '*Mumsnet* initially and there was a website on baby led weaning' (Geraldine, age 37, 3 children). There was a sense that baby-led weaning is a relatively new concept, which is more often introduced to mothers having babies now. Geraldine reported being considered 'loopy' by her health visitors when she started baby-led weaning her middle son, who is now five years old. She went on to say; 'I know from friends who've had babies more recently that they now all suggest that [baby-led weaning]' (Geraldine, age 37, 3 children). Those who wanted to adopt baby-led weaning did so because they had made the decision it would work as a strategy for them and their family. Whether they heard of it and then sought further information or came across it whilst on a general website or through friends, all the mothers who were using baby-led weaning sought further information of some kind. Furthermore, they were all committed to this style of weaning, therefore, were not dissuaded by health professionals who had not heard of the system of weaning, or who considered them unusual for doing so. These mothers negotiated expertise by finding alternative sources of support or becoming experts themselves, rather than looking for support from traditional professionals.

The desire to develop their own expertise, coupled with the effort exerted to actively seek information and be well informed, meant these mothers would not seek information and advice on what constituted a healthy meal from their own mothers. For them, currency of information and advice was crucial, as they positioned themselves as mothers who were aware of changing scientific knowledge, which would inevitably lead to changes in advice on diet and nutrition. These mothers considered experts necessary to inform them on advances in scientific understanding, and on such topics, professional expertise was both sought and valued, albeit most mothers did not accept information unquestioningly, as discussed above. By adopting this position these women considered their own mothers out of date. Although scientific understanding had moved on, they talked of how their mothers had retained their traditional positions on food and feeding a family. Although the meanings attached to feeding and eating together remained, the previous generation of mothers would not be considered appropriate sources of information and advice on the specific dietary needs of young children today. For this group of mothers being up to date with current advice was of greatest importance.

I talked to my Mum but, you know, it's a completely different world from when they brought up children, you know. Here it's, you know, different environment, it's just, things have moved on. And she didn't, she didn't breastfeed so, you know, that's completely, that's different. (Amy, age 35, one child)

By highlighting her mother's status as a non-breastfeeder, Amy is highlighting the distance between her mother and herself in their approach to feeding children, which is used as justification for not asking her mother for advice on feeding her son. When seeking out and receiving information these mothers trusted government and health

generated information that they considered backed by research. For these mothers, reliable knowledge had to be able to show provenance. On being asked which sources of information and advice they would trust the most, Catherine, Liz and Marisa all explained the sources they trust and why:

Catherine: Evidence based medical

Carol: And why is that?

Catherine: *laughs* because [partner] won't believe it otherwise
(Catherine, age 41, 2 children)

I tend to go to NHS and Food Standards and then I've gone to places like the baby led weaning site. That's run by the woman who did the original research and published a book, so I go there, and there are links off that site to others, so I use that. (Liz, age 36, 2 children)

The NHS, that's the place I would go to first, and then I will have a look to see what other people say as well, on the forums, and basically compare notes and see what, you know, what is most logical. (Marisa, age 35, one child)

These women privilege medical, scientific information, at least as a starting point. There were caveats to this trust as it had to fit with their instincts as mothers and to take into account their experiential knowledge, as discussed by Claire and Hilary:

Claire: I think definitely the government information, the book, I think that's the bible in the sense of going back to the book if I was in any sort of doubt.

Hilary: That literature and health visitors but I'm going to contradict myself a little bit by saying if I think they're talking sense so if I think oh that's sounding about right 'cause other times you can get..

Claire: Well I felt they were saying the government line as it were.

Hilary: Yes they are definitely, they wereso I definitely felt they were saying government led things. I think they've got so many, not necessarily targets, but they are so driven to. (Hilary, age 43, 2 children, Claire, age 40, one child)

To ignore experts would risk missing key new information, which these mothers are not willing to do. However, they also emphasise their own expertise and ability to assess any new information that they encounter. Health professionals have obligations to meet their targets and conform to guidelines, a position that is acknowledged by Hilary and Claire and which they use to demonstrate the discursive position of privileging instinct over slavishly following official advice. Regarding instinct as an internal ideal helps mothers justify their decision to ignore the more externally visible and seemingly incontrovertible 'science'. There is something very powerful about the notion of gut feeling, or instinct, which even the women who discursively followed advice and trusted science, felt they could not ignore.

None of the mothers who adopted this discursive position questioned their need for information and advice. There was a general feeling that science and related nutritional guidelines would inevitably develop as knowledge changed. This view relates to a general view of modern society as theorised by Beck (1992) and Giddens (1991) in which the process of modernisation has resulted in the proliferation of risk,

which individuals must be aware of and deal with. Mothers who took the position of actively seeking information assess expert advice and act accordingly in a constantly forward-looking process. The process is not simple, however, as these mothers show there is a need to become experts yourself in order to interpret the science and to take a position on which pieces of expert advice to act upon. These mothers saw their role as keeping up with changes, using their experiential knowledge to make decisions on how new information should be both interpreted and incorporated (or not) into their family feeding routines, all of which must be negotiated around other family commitments.

Mothers who privilege family information and advice

Not all the mothers I spoke to adopted the discursive position described above. Some discursively privileged their family information and advice rather than seeking out information from professionals. The mothers who adopted this position were young, mostly under twenty-five years old. These women talked of feeling conscious of their status as ‘young’ mothers and discussed their perceptions of the impact their youth had on how they were regarded by health care professionals. None talked about having been overtly treated differently by health care professionals but they felt they were viewed differently than older mothers. One young mother, Maisy (age 19, one child), talked of not being made to feel ‘welcome’ by staff or other mothers in a children’s centre. Whilst Vicky felt she was being judged by other mothers she encountered; ‘I just worry about probably people’s perceptions of me letting her eat certain foods’ (Vicky, age 22, one child). Feeling a sense of alienation or judgement, despite nothing being overtly said or done, shows these mothers are acutely aware of, and affected by, the dominant social discourse which brands young mothers as feckless, out of control and scrounging on welfare.

Macvarish (2010) argues that the political recourse to risk discourses typified by New Labour has led to the construction of the teenage mother as lacking both moral and rational agency. Teenage mothers are seen as a risk to society as they are considered inadequate to parent effectively which, in turn, will result in inadequate children who will repeat the cycle (Macvarish, 2010). Faced with these dominant views of young mothers, the young women I spoke to would turn to their own mothers, grandmothers or sisters for information and advice. That is not to say they were unaware of official guidance on feeding their young children, all talked of getting information from a number of sources and of seeking out information about feeding their children. They spoke of being active in making decisions about what to feed their children and of weighing up official advice and that of their own family members, who they saw as being more practical and down to earth.

Most of the young mothers talked of privileging their mothers over all others. They were the first port of call for anything related to childcare. These mothers saw themselves as evidence of the success of their own upbringing and saw no need to change the feeding patterns they had experienced, which they saw as based on sound principles.

I was brought up with ‘you need to eat your greens, you need to eat your meat, not to eat much red meat, you need your proteins, you need your fish’. I was brought up with a very wide variety of a diet, um, so it’s kind of. I cook for them, everything I used to cook, have cooked for me, all the healthy stuff. Yeah, they have junk food, what kid doesn’t? But, I don’t so much go on the internet and things and research anything like that. I just go with my natural instinct. (Emily, age 26, 2 children)

Emily works hard to show her knowledge of the constituents of what she considers a healthy and balanced diet, thereby demonstrating she is a good mother. Support from their own mothers, and fathers to a lesser extent, was important, as many felt less comfortable with health and other professionals.

Only two young mothers reported that they did not seek or receive support from their own mothers. One, who had her first child aged 19, was out of choice; ‘...my mum’s useless, no, I just basically got on with it’ (Nikki, age 27, 2 children), and the other, Millie: ‘well my mum hasn’t spoken to me since I told her I was pregnant’ (Millie, age 17, one child). Millie had been sixteen when she gave birth; she was living in the hostel for young mothers under the care of social services. Unlike Nikki, who was happily self reliant, Millie wanted familial support so turned to a friend whose own mother was ‘knowledgeable’ and she reported receiving the required information, advice and support from her.

All the young mothers spoke of their reasons for choosing to privilege family and friends. All wanted to present themselves as ‘good’ mothers and like the group of mothers who actively seek out information, they wanted to present themselves as having thought about their decision and to show that they are ‘good’ mothers who put the interests of their children first, even if they don’t want to follow all the official advice. Polly and Rachel are friends who talked of their reluctance to listen to health visitors. Polly starts by explaining why she does not like going to health visitors for information and advice: ‘They try and tell you what to do but I don’t like being told what to do’ (Polly, age 22, one child). The friends then talked further about the proliferation of rules and regulations, which they see health professionals trying to impose on parents:

They have gone stupidly overboard on it, really stupid, it's like you're not meant to start weaning them until they are six months yet when I was younger my mum did me at three months and you're not meant to stop sterilising after a year but I stopped mine at six months.(Rachel, age 19, one child)

These mothers equate authority with health professionals and being 'told what to do'. They both spoke defensively of making their own decisions for their own child 'it's not their child at the end of the day it's mine'. At the same time both mothers talked of getting information on feeding their children from their own mothers:

Polly: My mum, yeah, mostly my mum really she just turned round and said well whatever you are cooking you can give her anything.

Rachel: Mainly my mum she was just telling me what things he can and can't have straight away and then if anything it was the jar foods at ASDA. They are just quick and easy.

Polly: I looked at what age you can start putting cow's milk in your cooking for her for cheese sauces and that but apart from that I haven't really looked.

(Polly, age 22, one child, Rachel, age 19, one child)

Despite eschewing authority both mothers looked externally for advice, in both cases from their mothers. Like other mothers who looked to their family rather than professionals' expertise for advice, they are not questioning their need for external advice and that there are 'rules' around what and when certain foods should be fed to young children. These findings show that mothers all described primary sources of information and advice although it also shows differences between the sources. Few

mothers mentioned looking online for information in the early stages of feeding their children, however their use of the internet was ubiquitous.

The internet as a source of information and advice

Once their child was past the weaning period, mothers often used the internet if they were unsure of an issue relating to feeding their child. The internet was seen as a convenient way to search quickly for information, particularly related to a specific query, and was widely used by most of the mothers. Some mothers had favourite websites, which were used frequently, whereas some simply used the search engine *Google* to find what they were looking for. The mothers who were older tended to return to favourite sites including NHS direct, The Food Standards Agency and *Mumsnet* (a parenting website with information, forums, blogs and links) whereas younger mothers tended to use the search engine *Google*. The differing strategies relating to the internet reflect mothers' strategies when getting information on weaning where the older mothers would seek information from sources they considered backed by science and research whilst younger mothers, who privileged their families during the weaning period, were used to using the internet for many things and *Google* was the starting point of choice. None of the women I spoke to remembered being directed to any website, government sponsored or otherwise, by any of the professionals they had encountered.

The use of the internet reflects two issues, first the need to consult some external source for validation or reassurance that, as a mother, you are doing the right thing and second to feed the need to be constantly aware of changing knowledge, particularly scientific, on health and the contribution diet makes. All mothers, to some extent, talked of the need for reassurance and validation, which as discussed

above came from a number of different sources, including the internet. On occasion, finding information on the internet would add to confusion rather than clarify and in these circumstances, mothers would seek out further advice:

Then I think ‘oh I need a little bit more help on this one’ then I’ll phone up my local doctor’s and I’ll speak to Sister *name* who’s a triage nurse and I’ll ask her advice or I’ll phone *name*(*from the children’s centre*) and I’ll ask her advice on it. (Emily, age 26, 2 children)

Emily goes back to talking to ‘experts’ that she knows have helped her in the past. She is also demonstrating that she is discerning in that she will make sure she corroborates what she has found on the internet if it is not immediately clear to her. The second use of the internet, for keeping abreast of new knowledge and information, was most often talked of by the older mothers. These mothers were active information seekers and used the internet as one of their many sources of information and advice. For these mothers information was sought on many aspects of parenting, including feeding and they would constantly be reading books and consulting websites from which new ideas could emerge. This proactive approach was seen to have beneficial outcomes. For example, Geraldine, a thirty seven year old mother of three, wanted to try something different when weaning her second child as she hadn’t been satisfied weaning her first son:

It all went quite smoothly but I didn’t really enjoy doing it and I had by that point discovered *Mumsnet*, which has been a source of parenting information, and found out from there actually about

baby-led weaning and thought that was better and that I'd like to try that next time. (Geraldine, age 37, 3 children)

She mentioned it to her health visitors who at the time had never heard of baby-led weaning but she went on to use it for both her subsequent children and to continue to use *Mumsnet* as a source of information and advice. Geraldine wanted to demonstrate that she was discerning as she talked of the complex process of decision-making that had been involved in taking up baby-led weaning:

It's a balance, so then I would, if I think that sounds really interesting, look into it on more factual website and then find out something to back it up. So with the baby led weaning thing, I did look at the, um, the guidelines there are to how babies should wean and what they need and stuff like that, so I wouldn't just kind of look and go 'oh that sounds good I'll just do that' I like to have some facts behind. (Geraldine, age 37, 3 children)

Using the internet as a source was then never quite enough as discerning mothers needed further corroboration of what they had found. This demonstrated the real pride mothers felt in the amount of time and effort they put into being informed. For these mothers good mothering is negotiated through time and effort devoted to being well informed and up to date with current scientific thinking on food and health. It also links to notions of individual responsibility theorised by Giddens (1991) whereby individuals look to the future through assessing possible risks and planning their lives. Those who emphasised the time and effort expended in keeping up to date with developing scientific knowledge were the most forward thinking. They saw risks in not keeping up to date with changing advice as it related to the future health

and wellbeing of their children. For these mothers good motherhood lay not only in current actions but also in being informed about what possibilities lay ahead and how they could best protect their children's health in the future. Mothers who actively sought information in this way and changed their habits as a result of what they found, were most often the active information seekers described above. The ways mothers engaged with information and advice and who they privileged has been discussed above. Central to much of that discussion is the part played by those who claim expertise in different contexts. It is to the role of the expert and who can claim expertise that I now turn.

The role of 'the expert'

Expertise is contested between health professionals and mothers; as mothers become more experienced their notion of expertise also changes. Considering first professional expertise, mothers in all age groups and from all socio-economic circumstances talked of the importance of 'doing the right thing', which initially is defined by the expertise of health professionals. For most mothers in the UK, health visitors are the experts with whom they have the most contact, especially during the first year of a child's life. They are also the group of experts who monitor a child in relation to their developmental progress, which is done at set age-defined moments in the child's first four years. Additionally children's growth, marked by weight, is monitored on a regular basis, weekly initially then flexibly depending on the both parent and health visitor. Indicators of development, including growth, are based on a set of parameters constructed from observations of many children and, as such, are a normative set of expected achievements and stages in child development. In their accounts of their children's first year all mothers talked of taking their child regularly to the baby clinic to be weighed and most were aware of and recounted

how their child had ‘tracked’ on the height and, most importantly, weight charts. None questioned the need to conform to this monitoring, particularly during their baby’s first year, and the process of monitoring was seen as reassuring, particularly for first time mothers. Mothers with more than one child recalled how they had felt with their first child and then reflected on how they paid less attention to the charts with subsequent children. Experience builds confidence but even experienced mothers are not immune to the gaze of the expert. The power of the ‘expert’ in part comes from their potential to act should a child fall outside, or is consistently close to, the extreme cut-off points of the indicators (usually the 97th and 3rd centiles within the growth charts). Mothers are aware of this power and talked in the language of surveillance as they often reported where their child was ‘on the charts’ or that they had ‘consistently tracked normally’. Using the language of the technical expert mothers showed their own knowledge of the importance of such surveillance and wanted to demonstrate that they were aware of their child’s progress, particularly through their first year of life.

Different types of knowledge can indicate different expertise from the health professional who knows ‘normativity’, to the mother who has experiential knowledge about a few individual children. Mothers talked about their experiences with health professionals and the ways in which they were able to negotiate both knowledge and practice. Those who discursively talked of being active information seekers, prided themselves as being well informed and conscious of feeding their children according to best advice. For these mothers, health professionals were one of the sources of information or advice shaping their feeding strategies whether it was baby-led weaning or restricting sweetened puddings. Having decided on a strategy for feeding, these mothers found encounters with health professionals who

questioned their decisions very challenging. Having spoken with confidence about their feeding decision, mothers described how encounters with an ‘expert’ who challenged their strategy knocked their confidence and caused them to question their skills as a mother. Liz’s experience demonstrates the power of the expert. She is a 36-year-old mother of two daughters aged three and one, a midwife by profession and married to a doctor. Liz talked a great deal about how they used their professional judgement, and resources, to approach feeding their daughters. Making the right feeding decisions was important to Liz and she considered diet imperative to her daughters’ future health. Liz describes how, normally confident, she was completely thrown by an interaction with her local health visitor. She starts by discussing concerns over her daughter’s weight, which was not following a ‘normal’ trajectory on the weight charts:

...she (*elder daughter*) started off at the 50th and she dropped down the centiles and um, the best piece of advice they [health visitors] could give me was did I give her pudding when I was weaning her and I said, ‘no I didn’t’ and that was purposeful. I gave her fruit and milk puddings that I hadn’t sweetened but I didn’t give pudding every day, nor after every meal, and they said ‘Ah well that’s where you’re going wrong, you need to think of old school puddings and custard and you can’t go wrong. If you give her that sort of food she’ll be fine and she’ll start picking up her centiles again’. (Liz, age 36, 2 children)

Being questioned over a well considered strategy was difficult for mothers to deal with, but using the language of ‘right’ and ‘wrong’ was particularly challenging. This was especially the case for the mothers who prided themselves on the amount of time

and effort they invested in understanding the scientific information and advice on infant nutrition. By stating her strategy was 'purposeful' Liz demonstrates she is a reflexive mother which she went on to elaborate:

I just didn't feel like I was getting good quality information, that didn't seem, you know, and in the same breath you would hear other friends and you would be hearing in the news about overweight toddlers and 'You give them pudding every day? What kind of mother are you?' I felt like you can't win... I suppose what I found conflicting was I thought I had fairly straight in my mind what the health messages were. I am a health professional, I know very well where to go to get good information. I know, I would like to think I can distinguish between hearsay, nonsense and quality evidence and I thought I'd done my homework and my research really..... I guess I thought I was probably a little bit immune to it [being made to feel bad by health professionals], but you're not. (Liz, age 36, 2 children)

Expertise is shown to be situational by Liz as she is an expert in her job as a health professional, which confers on her the ability to source and understand scientific information, yet as a mother her expertise, of her own child, is undermined by another health professional. The realisation that everyone is vulnerable to feeling undermined by those in positions of authority came as a surprise to Liz because she had expertise through her professional role as a midwife. This is a powerful realisation as it shows the vulnerability of all mothers in this instance to the role of experts and surveillance in the ways that mothers negotiate their own version of good motherhood. Liz's experience was not uncommon. There were a number of mothers

who spoke of feeling foolish or worried by a health visitor, who they construed as judgemental. In retrospect, these ‘experts’ were seen as disrespecting the vulnerability of mothers, especially first time mothers:

...because it was my first baby, at six months she had to be able to, you know, I was very much looking at the books and listening to the professionals and that at six months they do this and at seven months they do that, at eight months they do that and she wasn’t quite on that classic time scale and I phoned the health visitor who really put the fear of god into me saying; ‘oh my goodness she’s not eating this that and the other, she’s not eating sandwiches, she’s not eating spaghetti bolognaise, well she should be doing that by this age’. (Hilary, age 43, 2 children)

Normative expectations that her baby should be on a ‘classic timetable’ led Hilary to seek advice. Hilary emphasised that she was doing what a good mother should by consulting professionals and written material to track her daughter’s progress. Rather than the support she expected, the health visitor confirmed Hilary’s fears and expanded them. Hilary shows how powerful the expert’s gaze can be, causing mothers in this position to question their knowledge and actions. The reaction of the ‘expert’ tapped into more deeply felt insecurities about being a first time mother without experience to fall back on. The ‘expert’ further failed by not giving Hilary practical ways to overcome perceived problems. Surveillance should be matched not only by imparting knowledge but also by practical advice. As Coveney (2006) describes, the role of the expert lies not only in advising on food consumption but on problematising food choice by laying down rules and regulations to which individuals or mothers, on behalf of their children, must conform. By focussing on

the negative, problematic element of consumption, such experts were seen as unhelpful, compelling mothers to seek advice elsewhere and avoid ‘experts’ altogether. In so doing, mothers looked to other notions of expertise including personal expertise, garnered through knowing their own children, expertise derived from the peer support of mothers who held similar positions to them and family expertise of their own mothers, grandmothers, sisters and aunts who had experience of bringing up children of their own. In this way, expertise was perceived as something far broader than Foucault’s (1988) conceptualisation of expertise as lying with professionally trained individuals. As a technique of governmentality (as discussed in Chapter 1) experts are seen to use their knowledge as power in the surveillance and governing of individuals. This research shows that mothers are aware of the power experts exert through their knowledge but they also challenge this exclusive version of expertise. Through mobilising their own knowledge and that of significant others whom they trust, mothers, like Hilary, felt the power of these traditionally conceptualised experts but turned to alternatively defined experts in order to negotiate good motherhood.

Mobilisation of alternative expertise was easiest when mothers were seeking general support or reassurance and when they judged their children to be healthy and happy. Under these circumstances, health professionals could easily be avoided as health visitors do not have the time to chase mothers who do not attend baby clinics as long as the health professionals have no other concerns about the child’s welfare. When mothers were concerned about a child’s health, however, they all talked of turning to health professionals for advice. In doing so, they brought their own expertise in the form of knowledge of their own child which equipped them to be aware when things were not ‘normal’ but this knowledge also left them frustrated

when their concerns were not taken seriously by health professionals. A number of mothers reported having children with health issues, relating to feeding, that required medical intervention. The most commonly reported health issue was reflux⁶ with mothers reporting a range of solutions to the problem. Two children had experienced more serious health issues, requiring a stomach or bowel operation. Both of their mothers felt they had struggled to be heard by the health professionals and, as a result, felt let down by the 'experts' consulted:

I felt quite let down really because, you known, the first thing, I suppose, you know, when your child is losing weight and you notice how, 'cause she's so small and notice she's losing weight it's quite a scary thing and the health visitors were like 'well she's not lost enough weight'. But to me, it was like, you know, you notice yourself how much weight she's lost and she was going from wearing size one and a half to two year clothes to going back to six month year old trousers and stuff. So it was hard for me, and the health visitors wouldn't do anything because she wasn't underweight enough, which I think is ridiculous...but I didn't want to wait to get that far, um, so it was a bit of a battle and I ended up having to go to the walk in centre at the hospital to get anything done. (Lorna, age 25, 3 children)

Lorna rejected one set of experts but could do so by mobilising her own expertise to make the decision to seek help elsewhere. In doing so, she turned to alternative

⁶ Reflux is a condition whereby milk in a baby's stomach flows back into the oesophagus. As the milk is mixed with stomach acid this causes discomfort to the baby. Severity of reflux varies as does the types of treatment offered.

experts as she realised the limits of her expertise and that she needed medical help. Mothers were clear that rejection of advice was done in the context of having considered what was being advised, doing further research (including asking friends and family) and making an informed decision; which could be considered as doing more than the professional suggested rather than less. Geraldine, a mother of three, whose middle child was not putting on as much weight as the health professionals thought he should be was advised to start weaning him before the recommended six months. She decided not to follow the advice of the health visitors:

Because I, well there were two reasons: one, I had done quite a lot of reading about it and I really couldn't see that baby rice was going to have more calories in it than breast milk and they had no answer to that. I kept saying to them; 'I'm feeding him all the time, he's fed on demand and he's not putting on as much weight as you tell me he should be so tell me what the problem with my milk is?' And they'd just say to me 'give him some baby rice'. ... I had a friend, at the same time, who had a boy who was over the hundredth centile, the opposite extreme. Not in the same area, but her health visitors were telling her, at four months, she had to take him, he was formula fed, but they were saying 'you've got to wean him because that will help slow him down a bit'. So I was looking at, going 'well you can't possibly tell me that you can give the same advice to a baby on the 2nd centile and over the 100th centile'.
(Geraldine, age 37, 3 children)

Awareness of seemingly contradictory advice from experts in the same field left Geraldine looking to her own expertise in making her weaning decision. As Giddens

(1991) argues, experts often lack clarity or agreement, which consequently leaves individuals making their own assessments on which decision to make. He further argues that risks in relation to health change over time as the aetiology of particular diseases are constantly being better understood (Giddens, 1991). Geraldine's awareness of the risks of early weaning and conflicting expert advice led her to trust her own expertise, gained through research, to make her weaning decision. She is able to negotiate good motherhood through explicitly documenting her knowledge of the official guidelines and her experience of conflicting advice which she used to justify her rejection of the expert advice she was given. Although neither of these mothers followed the advice of the health professional they were initially in contact with, the power of the expert remains as they justify, at length, the reasons for taking the course of action they did.

Not all experts are regarded equally, with specialist knowledge being considered as particularly important by some participants. Some mothers privileged and rarely questioned information and advice given by individual specialists. Referral to a specialist occurs because a child has a particular health issue in need of resolution, or because other avenues have not produced the results needed. Specialists, therefore, were considered as more knowledgeable than other health professionals, who are more used to dealing with everyday issues, and because they were the health professional who solved a particular health problem. Catherine talks about why she prefers to consult a specialist:

I find that GPs are also very general, so dealing with someone who specifically deals in a particular thing, like a paediatrician... like we have a friend who is a paediatrician and I talk to her about things, much better than the generalists, because the generalists are just the

average, the norm, that's what they are dealing with all the time.

(Catherine, age 41, 2 children)

Specialist expertise, even when experienced second hand, can assume greater importance: 'my sister for me on anything like. That is my first port of call because she has seen so many specialists' (Emma, age 35, 3 children). Specialists therefore are seen to have expertise of greater value than the professionals these mothers are coming into contact more frequently. This can be understood in relation to ever narrowing fields of specialism as medical expertise become more specialised. As specialisms narrow, the distance between lay knowledge and specialist knowledge widens (Giddens, 1991). Where mothers feel they can challenge the knowledge of generalist experts, for example health visitors, they do not have the same confidence or perceived knowledge to do so with experts in a specialised field.

Decisions to listen to or reject experts' advice depended on mothers' confidence, support networks and their prior experiences with health professionals. Many of these mothers had some control over their contact with 'experts', and could, for example, make the choice to reduce the number of visits to health visitors. One group of mothers, however, were not able to make these choices. A number of the young mothers I spoke to were living in, or had lived in, a hostel for young mothers. For them, being seen to be doing the right thing in the eyes of the expert was particularly important, and reflected a great deal of the power relations between the young mothers and the 'experts'. For this group, negotiating good motherhood in the first year meant following guidelines on good parenting in general, including feeding. Power lay with the hostel workers who made decisions on which mothers were ready to move on from the hostel and be allocated their own property:

...because *hostel* it's a support plan, so you have to do everything they say anyway...because you are moving to independence, so whatever they say that's reliable, you don't really have a choice whether you do it or not. You have to actually show that you do what they say. (Vicky, age 22, one child)

These mothers must demonstrate they are 'good' mothers, although, by saying 'that's reliable' Vicky is revealing a caveat, to show these young women, like many others in this study, were unwilling to blindly follow all that was recommended to them thereby retaining some control. The need to feel they were doing a good job and were seen to be responsible, despite their young age, was important to the young women I spoke to and, for some, this reassurance came from the 'experts'. Power and surveillance in this sense was not wholly negative but could also be seen as productive as experts were both judging mothers whilst also providing positive solutions to problems. Whilst issues of risk were important to these mothers to some extent, the gaze of the expert in relation to their being judged a 'good mother' was of more relevance. Foucault (1977; 1988; 1991) looked at the ways power and knowledge were felt by individuals and how they were used as a mechanism to govern societies. He saw that power was a technology exerted to determine the conduct of individuals whilst individuals used technologies of the self to conduct themselves in order to construct a moral self (Foucault, 1988). Surveillance exerted power over the conduct of these young mothers but through decision-making, they also wanted to use it to gain approval. Zoe talked of her relationship with a family nurse in her local health centre to whom she went for advice on any issue relating to bringing up her daughter:

Yeah, yeah it is important because a lot of me is just *unclear* I like to hear that I'm doing good with her, do you know what I mean, it's good for me to hear that I'm doing really well with her. (Zoe, age 19, one child)

This expert was trusted and although she exerted power over Zoe that power was productive as her approval reinforced to Zoe that she was meeting the expectations of a 'good' mother. Much of the discourse relating to expertise and knowledge raised the notion of trust as a recurring theme. Trust was raised in relation to the information and advice given in material form but related far more to the person delivering the material than the material itself. Overall relationship building was of most importance in the development of trust for mothers of all ages and from all social groups. For the young mothers who had talked of feeling judged, as discussed above, trust revolved around feeling secure in the professional relationships they made.

I don't know, I think it's more the way she comes across, um, I don't know, I think that over the time she's built that trusting relationship with us..... She makes sure that you feel involved and that she's there for you. (Stef aged 20, one child)

Stef is underlining the importance of professionals who do not espouse the social stereotyped views of young mothers as feckless, out of control and scrounging on welfare, as discussed by Macvarish (2010). Trust is earned through listening and making mothers feel welcome. Mothers most often trusted health professionals and government-produced materials but as with taking on information and advice, this is not done unquestioningly:

That literature and health visitors but I'm going to contradict myself a little bit by saying 'if I think they're talking sense', so if I think 'oh that's sounding about right'. (Hilary, age 40, one child)

Highlighting her agency, mothers like Hilary retain their power through using their experiential knowledge as the most important decision making factor. Trust therefore becomes bound up situationally with mothers choosing different expertise depending on what help they are seeking as demonstrated by Emily:

Now, I do trust my health visitors and my consultant and my nan. They are about the only people that I trust. (Emily, age 26, 2 children)

Emily's list of trusted individuals gives equal weight to 'experts' with totally different skills and knowledge, showing again that mothers do not see expertise as the preserve only of formally trained professionals.

Surveillance and judgement were talked of as coming from many sources, not only those in positions of power. Negotiating their individual versions of good motherhood meant that mothers had to deal with the ways in which others viewed their feeding decisions. These judgements, of course, flow in both directions and mothers used the decision-making of others as a way to both justify and feel good about their own position in feeding their children.

'Others': how they are viewed and view you

When considering power, knowledge and the ways that individuals are judged, it is not experts alone who turn their gaze on parents. Family, friends and those who exist in the same space as parents, are all seen as important points of reference. All

the mothers I spoke to benchmarked what they were doing against others. Being part of a group of like-minded mothers gave some women in my study assurance that they were doing the right thing:

Yeah, most of my friends think the same way that I do and they'll offer something that's quite a rounded balanced diet for lunch. There's always like fruit and things on offer whenever we go out with friends. There's a few who always have cakes and biscuits, and they think they're just being nice to the children don't they, but I don't see them every day so it's not like a big deal. If it was every day, I think I'd have to say 'please don't keep giving him that', 'cause then when he's eating that he's not eating something else when he gets home. (Beth, age 41, 4 children)

Beth spent time with friends who act the same way as her whilst making a judgement on those who 'always have cake and biscuits' showing that she would not align with them. By choosing with whom she spent most time, Beth retained control and did not need to challenge those who held different priorities to her. If a member of the group, who are judged to hold the same values, challenges a mother's action, this can be felt as a direct challenge of an individual's 'good' motherhood. Liz recounts such a situation when she was out with a group of mothers, all of whom had met in antenatal classes during their first pregnancy:

I remember us all going to, meeting up to go to the pub for a pub lunch and the babies were somewhere between six months and a year. I can't quite remember exactly how old they were, but I fed, it was for mums to have their lunch, but to take the babies too, and

I decided to feed *older daughter* before we went and I just took some fruit and snacks and stuff. I can remember, I had something and chips and I gave her a chip and my friend saying ‘I can’t believe you’ve just given her a chip’ and I said ‘well it’s only potato and you know there’s nothing inherently awful in a chip, it’s fine you know, you need to , that’s the real world’. But, I can remember feeling dreadfully challenged, and really kind of looked on for a friend to say out loud. (Liz, age 36, 2 children)

Mothers talked of the importance of like peers who support and reinforced their decision-making regarding many parenting decisions, including feeding. Being challenged by one of her peers was harder for Liz to dismiss compared to challenges by health professionals, whose expertise she could question by calling on her own judgement, whereas peers were supposedly bound by like-minded values of rearing children. This example illustrates that mothers not only notice what other mothers, whether friends or strangers, are feeding their children but they also make judgements on them. Although much judgement is internalised mothers are aware of others’ gaze and judgement. The incident clearly stuck with Liz as she then went on to describe how she had raised the issue not long before I interviewed her, two years after the incident. On reflection, Liz describes how they had been as mothers at the time:

We were all caught up in this children, dreadfully, you know, nutritious, organic everything and that wasn’t, in her mind, that wasn’t a good healthy food to give to your child. (Liz, age 36, 2 children)

Liz talks of the way she and her peers were completely focussed on their narrow version of healthy eating for their children. Using the terms ‘caught up’ and ‘dreadful’ she is emphasising their myopia and desire to do everything ‘right’ according to their notion of how to feed young children. These are examples of the way surveillance is embedded within society and is another example of Foucault’s (1988) notion of governmentality whereby technologies of power are exerted through others, in this case friends’ questioning of mothers’ feeding strategies, which then affect mothers through technologies of the self whereby mothers subsequently act in order to achieve good motherhood through their actions. Friends are only one group who exert power in this way.

Many mothers talked of the importance of family support in raising their children, particularly the younger mothers, but family members can also challenge mothers about their approach to feeding their children. Sam has a son whom she finds difficult to feed, and often turned to her mother for support, but this often led to challenges:

Sam: It’s stressful when my mum comes round ‘cause she don’t half moan about it, um..

Carol: So what does she moan about?

Sam: ‘Oh you want to feed him bloody properly, feed him the same time as she does. If he doesn’t want it, tough, don’t have it. Don’t go making him something else. I tell you, when you were younger, if you don’t want my dinner you didn’t have it. I didn’t make something else.’ (Sam, age 22, 2 children)

Earlier Sam had questioned the strategies she used to get her son to eat, but there is something different between questioning oneself and having your strategies questioned by another. This is particularly powerful if the 'other' is your mother, who you have previously stated was your most important source of information and advice. Rather than displaying expertise per se, Sam's mother is referring to her experiential knowledge of feeding Sam. Some mothers talked about perceiving that 'others' were watching what they were doing and judging them for their action. It was more often the younger mothers who talked of feeling judged by 'other' mothers, most often those who were older. Even when the challenges to mothers' actions were not direct, they could be felt strongly, as articulated by Vicky, talking about her breastfeeding experience:

Yeah I would have preferably liked to go for at least six months, um, but 'cause I did feel when I stopped it, I didn't want to stop it, but I felt like I had to, to have a social life, um. And then obviously, I think I was doing groups with other mothers who were a lot older than me, they were in their thirties and obviously I was only nineteen and obviously they were all breastfeeding their children so I felt like oh maybe I should have carried on but then..

(Vicky, age 22, one child)

Vicky articulates the dominant social discourse that portrays breastfeeding mothers as older and middle class. Nothing needed to be said directly to Vicky for her to feel the power of that discourse, bound too with the 'breast is best' discourse, which brands mothers who do not breastfeed for six months as lacking and inadequate. The apparent social norm of breastfeeding for six months does not take account of an individual's material or social circumstances, for example the need to return to work

or support at home. Whether or not the women in the group did judge Vicky has less relevance than her feeling judged. Furthermore, by stating that she put herself and her desire for a social life ahead of what she 'knew' was best for her baby's health (breastfeeding for six months), Vicky is leaving herself vulnerable to judgement by 'others'. Even indirectly, mothers feel the gaze of surveillance, with many, like Vicky, working hard to engage with technologies of the self to be able to reclaim a moral self as good mother.

How mothers feel when expert advice is followed but does not produce expected outcome: under and overweight children

Mothers who trust expert advice do so with the expectation that their child will be healthy as a result. Not surprisingly, then, mothers feel let down when they feel they have followed all the advice they have both been given and meticulously sought out, yet their child is deemed to be falling short of targets, which are set by the very experts whose advice they have followed. The most frequently monitored target is weight with children regularly weighed during their first year and then at prescribed intervals until school age. Children at either end of the 'normal' range are scrutinised further. Childhood obesity is constantly in the news with much attention being levelled at parents, particularly mothers, who must shoulder the burden of responsibility (McNaughton, 2011). Mothers are aware of this responsibility and all the mothers I spoke to at some point in the interview mentioned weight monitoring, either where they 'tracked', with pride at their 'normality' or concern at their 'abnormality', or that they avoided the monitoring. Avoidance of monitoring occurred more frequently with a second or subsequent child once the mother felt more confident and able to drop under the radar of health visitor attention. Mothers also showed awareness that children do not perform in 'text book style' against any

of the milestones from cutting first teeth to eating a varied diet. Jones et al. (2011) found that parents observe from birth that children grow at differing rates and exhibit differing body shapes. This was also true of the mothers I spoke to, especially as all talked of the importance of peer groups with whom they would discuss any number of parenting issues from sleep to toddler tantrums. Such experiential knowledge is not taken into account by the medical model, which charts linear growth rates, therefore moving within such charts was also seen by health professionals as an indicator for added scrutiny. A child's first year of life is dominated by a concern for putting on weight in a steady trajectory (Jones et al., 2011; Pagannini et al., 2007) after which the focus becomes more about making sure a child does not put on too much weight. A number of mothers discussed children who at some point had been judged under- or over-weight. All felt challenged by the additional monitoring and scrutiny this brought but, more importantly, they felt it undermined their standing as a good mother. Weight is considered a proxy for 'health'; therefore, mothers felt their role in keeping their child healthy was also being questioned. The role of the expert is crucial here as the health visitor who is monitoring weight is also giving advice on feeding that child which Nettleton describes as a 'double-edged sword of welfare and surveillance' (Nettleton, 1992: 149). The disciplinary power of the health visitor lies in their role in surveillance (Peckover, 2002) yet mothers who feel they are following such experts' advice feel let down by expertise when their child fails to conform to expected outcomes.

Mothers spoke emotionally about hearing that their child was categorised as overweight, according to expert definitions. Claire, a forty year old mother of one daughter, is very interested in fitness, cultivates two allotments and is very confident

about her knowledge of healthy eating. Talking of taking her daughter to her regular checks Clarie recalled being told her daughter was overweight:

...the one time, it was at the two year check or something, and she was really at the top [of the centile charts] and the health visitor said 'oh well she's rather, you know, on the large side for her age' or something so 'do you think you should do some extra exercise with her or something?' And I thought 'well we go swimming with her we do all these things we have two allotments' and I just thought 'well I think we probably do more than you do' so I didn't really take it too badly but some people would get really worried about it wouldn't they.(Claire, age 41, one child)

Claire used her knowledge of the importance of height and weight being in proportion, coupled with her knowledge of their activity levels to dismiss the challenge that her daughter was overweight. She then said she understood that the health professional was 'delivering the government thing about obesity', which she used as explanation for being targeted in that way. Despite feeling her parenting had been challenged, she had brushed it off as she was confident through her knowledge and understanding of health that her daughter was healthy. Lynne, a thirty nine year old mother of two girls aged three years and twenty months did not have the same reaction:

I got told, when I took *older daughter* for her two year check, I was told she was overweight and *younger daughter* only six months. And I cried, because I cook a lot of my stuff from scratch, she loves her fruit and probably now they'd still say she was

overweight. She has a little belly but to me it is a toddler belly. She had kind of sprouted up. But that broke my heart, and I will not repeat what words were said when I told my parents or my sisters, and I was then told if I had come back two weeks later she might have been fine because she might have gone through a growth spurt. But I was still hormonal, *younger daughter* was just six months. I was breastfeeding, you know, for *older daughter* until she was one, I pureed her fruit, she had natural yoghurt she never had those fromage, you know. I did everything, near enough, by the book, breastfed. (Lynne, age 39, 2 children)

Lynne experienced the news that her daughter was overweight as devastating. This was made worse by the fact that she felt she had done everything that the experts told her to do ‘by the book’, to ensure that her child would be healthy. Lynne not only described all the healthy foods that her daughter liked, and how she cooks from scratch but how she is aware of so many more mothers who take far less care and attention: ‘I go to some houses, like one of my friends, and her son constantly lives off biscuits and really thick diluted orange juice’. Using the example of ‘others’ she demonstrates that the attention of the expert is unjustified; furthermore, she talks of doing everything ‘by the book’, thereby asking what else she could have done to avoid her current situation. Lynne’s solution to being challenged by the health visitor was to avoid her: ‘I had a phone call but I ignored it and then when I bumped into her I just said to her ‘I’m not coming back because in my eyes my daughter is healthy’. Lynne sees her daughter’s diet as healthy, irrespective of her weight, which echoes other studies, which have shown that mothers assess their children’s weight in comparison to their peers and their ability to perform tasks, clothes size, and

appearance (Booth et al., 2009; Jones et al., 2011). Experts in these circumstances exert a great deal of power over mothers which is felt acutely and which must be addressed in order for mothers to regain their good motherhood status through feeding their children.

Conclusion

This chapter has shown that expertise for the mothers in this study is not solely the preserve of those who have legitimacy through professional qualifications as is theorised by Foucault (1988). Expertise is seen as situational therefore, in relation to feeding children, does not lie with one particular group of professionals. The mothers in this study accepted the need for information and advice on feeding their children relatively unquestioningly. This was particularly the case of the older mothers who positioned themselves as active information seekers. They looked particularly to nutrition science for the most up to date thinking on the best way to feed their children. They also had expectations that such knowledge would change, to some extent, over time and would not always be in consensus. It was important for these mothers to have the ability to seek out and understand what constituted good information through using scientific and government based information sources. Where an area of advice was emerging, as in the case of baby-led weaning, they were happy to become experts themselves and negotiate their own good mothering through the effort expended in being well informed.

Younger mothers most often privileged their own mothers and grandmothers for information and advice. Current discourses, which demonise young mothers (Macvarish, 2010), were alluded to by the young mothers in this study who talked of feeling self conscious around health professionals on account of their age. For these

mothers expertise was experiential and their mothers and grandmothers represented experience. Using themselves as justification for the success of their upbringing, they did not feel the need to seek expertise from professionals. That said there were occasions where professional experts were consulted and these were most often linked to emerging medical issues.

Foucault's (1988) notion of expertise lying with professionally qualified individuals who then hold knowledge and with it, power was seen in relation to the monitoring of children. Most of the mothers I spoke to were aware of growth charts and where their individual children fitted within these normalized expectations of growth. Seeing very young children progress was considered a good thing and most mothers went for regular monitoring until their child reached the age of around two years. During this period some mothers were challenged on their child's development (both overweight and underweight) and were willing to counter the professional expertise through mobilizing their own knowledge and understanding of nutrition and variable growth rates rather than 'text book' rates of development. By doing this, they could still negotiate their sense of good mothering by constructing alternative knowledge and expertise. Professionals consider the outcomes of feeding in the form of growth and only consider how the child is being fed should it not be taking a normal trajectory on the charts. Although they are the source of information on child feeding, should it be required, they do not monitor what is being fed to individual children, only enquiring if the child is not progressing as expected.

Foucault's (1988) notion of power being exerted through a panoptic gaze can be seen to the extent that mothers are aware both of what other mothers are feeding their children but also that other mothers, and family members, are watching what they are doing. Foucault (1988) saw the power of the panoptic gaze residing in its

constancy. In the example of feeding children the power would lead mothers to be constantly aware of what they should be doing and what they were managing to achieve. The examples in this chapter show the power of the panoptic gaze but mothers did not feel that as a constant presence. The sense of being judged on what you feed your children will be explored in more detail in the next chapter, which considers the opposition of good food and bad food and how this categorisation can be understood.

Chapter 5: Good Food/Bad Food: Getting the balance right

In the previous chapter, I have presented the ways in which expertise is constructed and experienced by mothers. Expertise takes many forms with mothers drawing on different constructions of expertise at different times, depending on their individual circumstances. Experts too take many forms from the specialist health professional to a group of peer supporters and again mothers were shown to draw on different experts at different times depending on the specific information, support or advice that they were seeking. Whilst experts and expertise may help mothers make decisions on what to feed their children, as well as be used to justify their decision-making, foods themselves have very powerful discursive roles in the negotiation of good motherhood.

Much of the following discussion revolves around the positioning of foods or feeding strategies in opposition to one another, much of which involves the negotiation of foods into categories of ‘good’ or ‘bad’. A practice Cook (2009) found common amongst the middle class mothers in his study who negotiated both the categorisation of foods as ‘good’ or ‘bad’ and which foods they thought were appropriate for children to consume. Cook (2009) argues that mothers set up rules and boundaries around food primarily to establish order in family feeding, which helped the mothers in his study to establish themselves as ‘good mothers’. Although his study only included middle class mothers and was focussed on the commercial and consumptive practices of mothers and children, my study found many of the same issues amongst all the mothers I talked to albeit it articulated differently. In considering the broader issues of food decision-making, two forces are prevalent in

the desire for mothers to establish themselves as ‘good’ mothers. The first relates back to the idea of the risk society (Beck, 1992; Giddens, 1991) as discussed in detail previously, but here notions of risk are not about particular foods consumed or the establishment of a healthy diet in the hope of future health, rather it is about establishing a moral self as mother. Murphy (2000; 2003) showed that mothers who decided not to breastfeed, against the advice of experts, had a need to justify their decision to enable them to regain their position as ‘good’ mothers. Murphy’s (200;2003) work highlights the moral risk to self of not feeding their babies breastmilk which could be seen in the discourses of the mothers in this study who constantly justified their food choices in ways to establish good motherhood. The second force is that of surveillance as a mechanism of governmentality (Foucault, 1977; 1988; 1991), which also plays a role in mothers’ food decision making. Again, notions of governmentality have been discussed previously but it is the case that in considering how they defined balance and established food rules within their individual families, mothers spoke of the need to negotiate and the role that others take in their negotiation. Lupton (2012) sees the family as the site at which Foucault’s ideas of governmentality intersect with the risk society thesis. It is, she argues, where individuals voluntarily take up the responsibility for their own health (and that of their children) whilst absorbing the intensive parenting notion of accounting for risk. How this plays out through the specific discursive roles attached to types of food and feeding practices will now be examined.

The Biscuit

The biscuit epitomizes a high sugar and fat snack food that is not only unnecessary, in dietary terms, but which elicits a great deal of moral discussion. Eighteen of the interviews I conducted elicited spontaneous discussion of ‘the

biscuit'. In discussing the discursive role of 'the biscuit', I will consider issues of food's role as weakness or pleasure, notions of balanced eating, and control.

Weakness or pleasure

Mothers regarded 'the biscuit' as an inevitable part of toddler life but their attitude towards it differed greatly, some considering it the scourge of the playgroup whilst others thought of it as just another food to be treated as part of a balanced diet. For those who took the former position 'the biscuit' was something that they would not buy and have at home and would ideally like to keep out of their children's diet. Its ubiquity was a source of stress for these mothers as described by Catherine:

When I go to morning tea it's all biscuits, there is no fruit, when I go to *name of playgroup*, you know all the playgroups, it's all biscuit there's no fruit for the children. Biscuits may be cheaper, probably that's why they do it, but the children just get to know the playgroup as the biscuit group and there is always just a big bun fight to get the biscuits, you know, and I've said to the parents who run it, I said 'why can't you have grapes or carrot sticks or even breadsticks or something else because you know this is really mad?' (Catherine, age 41, 2 children)

Mothers like Catherine are faced with a dilemma. They cannot avoid 'the biscuit' if they wish to take their children to playgroups but when at the playgroup they lose control of their child's eating. Catherine portrays the children's desire for getting to the biscuits as a lack of control and, equally importantly, restraint. Mothers therefore had to negotiate their role as good mother in taking their children to playgroups, which are seen to foster

sociability in children, whilst relinquishing some control over consumption of ‘the biscuit’ which they would not normally allow. Other mothers took a more holistic view of ‘the biscuit’ and saw it as one ‘treat’ food amongst many:

...every day he gets something whether it’s a biscuit or a cake or something like that but, um, no it’s still definitely a treat, he’s not allowed to come home and stuff his face with biscuits. Although if you put the tin out and didn’t watch him he will (laughs). (Emma, age 35, 3 children)

Mothers like Emma did not give ‘the biscuit’ particular status, although it was mentioned as a ubiquitous snack food type, amongst all the snacks and treats her son is allowed. She did however justify her position as good mother by noting that she imposed some control over its consumption. A smaller group of mothers talked of ‘the biscuit’ as an everyday food amongst many talking about it as a snack food enjoyed by their children alongside or in preference to others. Nikki, for example, gave biscuits and fruit equal status as snack foods which her boys could have if they said they were hungry: ‘I tell them there’s biscuits and there’s fruit’ (Nikki, age 27, 2 children). Another mother, Eve again talked of biscuits and fruit as snack choices but noted ‘he’d prefer biscuits to banana’ (Eve, age 17, 1 child). Nikki and Eve negotiate their own versions of good motherhood through satisfying their children’s desire for snack food but by mentioning the option of fruit, they are also adhering to the social norm of fruit as the most appropriate snack.

Deriving pleasure through eating has a long history, as does the need to balance that pleasure with the health of the body (Coveney, 2006). As science has become more prominent in governing what should be eaten for maximum health,

pleasure in eating has been given lesser importance. The construction of hierarchies of food based on ‘good’ and ‘bad’ food dichotomies further requires a moral self to conform to what is good for the body rather than what gives greatest pleasure (Coveney, 2006). Within modern neoliberal societies where parenting practices are intensified, Coveney (2006) further argues that parents are entreated to simultaneously give their children choices alongside ensuring that they eat nutritious food. These oppositional struggles can be seen in mother’s attitudes towards ‘the biscuit’ and through wider debates about getting their children to eat what they want them to eat whilst simultaneously gaining pleasure through food.

One of the ideals of good mothering that mothers set up for themselves was enjoying food and meal times. Mothers wanted to provide food that was healthy, enjoyed and mealtimes that were fun. In talking about what she saw as important in feeding her family, Emily states both health and enjoyment are central:

Their health, their enjoyment of food because I always think that food should be fun, food needs to be fun sometimes to encourage children to eat, experimenting with different foods, different textures, different tastes, um, but it’s mainly that they’re happy and healthy with what they’re eating and what they’re getting. (Emily, age 26, 2 children)

Children’s enjoyment of their food was expressed as a crucial element of mothers’ own enjoyment of feeding their family. Mothers talked very powerfully about the cyclical nature of feeding children and how that reflected firmly on how they felt as mothers. When children are eating what they are given, mothers feel good about themselves and if children then express pleasure and joy whilst eating this is a true

affirmation of self as good mother. The power that children can exert over their mothers is articulated by Marisa:

The most important is, I think, when she's eating well and it makes me happy, um. Now she is starting to talk and when she likes something she says 'nice, wow' and it is the best things for me that I can hear and then she eat it and has an empty plate and asks for more, I think, you know, it is the happiest moment for me. (Marisa, age 35, one child)

Mothers accept the responsibility for their children gaining pleasure from eating almost without question although their strategies for achieving it may differ. Such positive feelings are experienced with the knowledge that it may be transient:

You know when she eats well it's fine, but if something happens she didn't eat 'oh it's my cooking maybe, or it is something she doesn't like, or maybe she doesn't feel well or' so something like this so always you can find some, you know, case to worry. (Katya, age 37, one child)

Katya never questions her responsibility for providing foods that her daughter will enjoy and taking the blame should food be rejected. Even when things are going well mothers like Katya are looking towards the next problem indicating the constant nature of responsibility. Not all mothers felt this as a constant pressure although most talked of thinking about food and feeding their children as a constant activity. One way that mothers talked of negotiating pleasure and constraint was through the notion of balance.

Good and Bad Food in Balance

Having discussed the nature of balance in relation to health in Chapter 3 I will expand on that argument by looking here at particular foods which mothers thought were good or bad therefore needed to be in balance. I established that mothers overall look at foods over the period of a day or week, balancing what has gone before with what will come next. There was consensus over foods that should be encouraged, most notably fruits and vegetables, which all mothers talked about as something they encourage. Fruit had a particular role to play as a ‘good’ food and dietary saviour:

I just think I cook for my kids what I would cook for myself and I think ‘cause I know I’m not the world’s healthiest eater but I think I just know the best food is cooked from scratch and you buy good quality ingredients and I just think I just apply that to my children. Plus, I try and shove as much fruit in them as I can. (Hayley, age 35, 3 children)

Hayley sees fruit as a way to balance out any shortcomings in the diet although she points to other imperatives of a healthy diet. Mothers talked at length about the particular fruits and vegetables that their children ate and enjoyed, which they did not do with regard to any other food group. There were specific foods that particular mothers wanted to point out their children had never eaten or which were banned including fast food, fizzy sweetened drinks and chips. Most of the mothers who talked of foods which they saw as ‘unreasonable’ to feed their children were older, middle classed mothers who wanted to impose strict rules on their children’s eating habits. This was not exclusively the case as Stef (age, 20, 1 child), a single mother,

noted that ‘I’ve never given her pop’. Sweetened drinks hold a similar significance to ‘the biscuit’ and Stef is using this example as a way of demonstrating that she is a good mother in restricting its consumption. Mothers felt the need to list foods that their children ate despite being told that what they ate specifically was not the focus of my study. It was something that was done particularly by the younger mothers, many of whom were single parents. Vicky talked about the foods her daughter ate in this way:

Well she’s always loved fruit, vegetables, um, and plain, well she’s never, um, been very unhealthy like she does eat a lot of rice, pasta, um, salad. (Vicky, age 22, 1 child)

In listing ‘good’ foods that their children were willing to eat, these mothers were demonstrating their good mothering by conforming to normalised notions of a healthy diet. They were able to demonstrate knowledge of officially defined ‘good’ foods, which they wanted to emphasise their children consumed. It could be argued that my asking a general question about how easy they found it to feed their children and what particular difficulties they faced was seen as some kind of surveillance and that their emphasis of the ‘healthy’ foods consumed was done to construct themselves as good mothers. That said, most mothers balanced their talk of healthy foods with talk of foods that are deemed unhealthy. Mothers talked of living in the ‘real world’ where, even if they wanted to, their children would gain access to foods of which they, as mothers, would not encourage the consumption. The categorisation of foods as ‘good’ or ‘bad’ was, for some mothers, further complicated by issues of quality. Issues of quality were only discussed by the middle class mothers who had the capital to be able to consider quality in their food purchasing decisions. A few

talked of buying organic, particularly fruit, vegetables, meat and milk. Hayley's discussion of sausages illustrates this discourse well:

I'm quite fussy about meat but I think most people are. But then my children prefer revolting sausages, um, but I call a revolting sausage like a Waitrose essential sausage so not like a kind of a frozen banger or a value sausage or something like that. (Hayley, age 35, 3 children)

Issues of taste can be seen clearly in the way that Hayley discusses her children's preferences. Hayley's assessment of 'the sausage' can be understood by looking at Bourdieu's (1984) hierarchies of taste, discussed fully in Chapter 2. Bourdieu (1984) argues that food choices are based on either the taste for luxury, in the case of the upper classes, or the taste of necessity, seen in the lower classes. He further contends that working classes develop a taste for what they have to eat which persists even when their economic capital circumstances change (Bourdieu, 1984). Furthermore, upper classes develop tastes which distinguish them from the working classes in order to create distinction. Initially showing disappointment with her children's taste she then clarifies that the 'Waitrose' sausage is higher quality than other brands available, showing their distance from necessity. In stating that 'most people' are 'fussy about meat' she is aligning herself with like-minded middle class mothers disregarding those who have not got the luxury to think about the provenance of their meat. Knowing her children's preference for what she regards as 'revolting' sausages, Hayley, manages their consumption by control over the types of sausage she buys. The issue of control from access to biscuits to the purchase of organic meat was important for mothers.

Keeping or Losing Control over Feeding Children

All mothers discussed issues of control as they talked of ways in which they tried to negotiate their children's food consumption. Control was contested within the family and between wider family members and was felt as both a positive and negative force at different times. Most mothers saw control in terms of their ability to balance their child's food consumption, focussing on 'good' and 'bad' foods in different contexts. Some mothers talked of being 'in control' of their child's eating through determining what food purchasing and in the way that they planned and prepared the food that was eaten by their children:

I feel in control of what they eat in terms of, I provide entirely what their choices are, so everything I give them I am happy for them to eat. But I let them have some control over how much of that they eat, and if they don't want to eat certain elements of their meal then that's okay with me. (Liz, age 36, 2 children)

Liz reflected many mothers who talked of controlling what came into the house and what was cooked but acknowledging their children's agency in ultimately controlling what and how much of the food provided they ate. Most mothers noted children's agency from a very young age and considered their own control to inevitably change and diminish over time, particularly once their children started school. Those who had older children reported their experience of this being the pattern whilst mothers who only had pre-school aged children envisioned this situation as an inevitable part of their children growing up and moving out of their control. Going to school was pivotal in relinquishing control as school age children had opportunities to make their own choices:

Less now that the boys are at school. I think because you can't, they get a choice over what they have and they have all the control over that, but when they have a packed lunch, half the week, I have control. (Geraldine, age 37, 3 children)

Some mothers, like Geraldine, negotiated control through insisting on packed lunches for part of the week. Such negotiations were easier whilst the children were in primary school whereas secondary school aged children were further from their mothers' influence. Mothers with older children spoke of the inevitable loss of control despite their best efforts to instil healthy eating from a young age. Beth describes her lack of control and the ways she tries to deal with it:

Very little [control] over the older ones. I don't give them money at the moment, um, and I don't know if that would help if I gave them some money. Then they'd have, then they wouldn't feel quite so eager when they're given it by their friends perhaps, if they got their own money. They have to earn their own money you see, *daughter* does a paper round and she had a job at Christmas. I do feel as though I have very little control of them out of the house and really I've got no idea what they're eating. (Carol: what about in the house) Well in the house I don't buy sweets and biscuits, well I do buy some chocolate now and again that they're allowed to have, but I don't like biscuits and I don't buy crisps that kind of thing, um, again maybe if I did maybe they wouldn't be so mad on it I don't know. (Beth, age 41, 4 children)

Beth's indecision over whether or not her strategies are working illustrates the core tensions mothers have in negotiating good motherhood. Controlling what is in the house is a positive strategy with 'the biscuit' representing 'bad' foods, which Beth does not buy, however, she questions the effects of prohibition versus moderation. For many mothers knowing what to do is fraught with uncertainty especially if, like Beth, their children all show different responses to the same regime. Beth's two daughters were aged 20 and 16 at the time of the interview and had very different attitudes to food with the younger being more health conscious compared to the older daughter who lived off pizza and takeaways whilst at university. Mothers with older children all spoke of the impact of 'others' on their children's eating habits and how their influence was reduced. One mother spoke of the lessons she had taken from bringing up an older daughter:

Total control [of son] at the moment. He's only four, so yeah I think I have a lot of control, but I think, I've kind of learnt lessons as well. I was a lot stricter with my daughter with food. I think as well, being vegetarian, I mean my daughter wasn't allowed *McDonald's* at all. She wasn't allowed that food, um, and when she hit about thirteen, fourteen, she started. She had her own money, because she had a Saturday job, she started to eat a lot of it on the way back from school and, um, funnily enough she stopped quite quickly because she started to put on a bit of weight and her skin went bad and she's like 'what's this?' And I said 'well you're eating *McDonald's* all the time and you're eating junk food, you know, you're buying lots of crisps, you're buying lots of chocolate, you're not used to that'. And she stopped and went back to normal

but she still likes it occasionally and I think. That's what I was saying earlier, I think that it's really important not to deny anything because I think the fact that I had with her, once she became of an age that she had that little bit of independence, and that little bit of money, that became really important, she could have that. (Emma, age 35, 3 children)

Both mothers struggled with how to position themselves between prohibition and moderation. Beth retains her prohibition stance whereas Emma has changed her position, which she hopes will prevent the reaction of her eldest child in her younger children. She thought her previous strategy made unavailable foods more appealing, although she provides a rebuttal to the claim that once children start on forbidden foods they will not stop. What is clear from the accounts of these mothers is that they still work hard to negotiate good motherhood by showing they have both thought through their strategies on controlling foods and that they are willing to some extent to make changes. Losing control of older children who were operating independently outside the family home was a future many mothers envisioned, however, they also described tensions when they took their younger children to visit other people who did not share their feeding strategies.

Most of the tension and disapproval of 'others' and the food they provided centred on the provision of sweet treats. Like 'the biscuit', chocolate and sweetened treats were seen as something unnecessary yet unavoidable. Most mothers talked of putting limits to the availability and access to such products, which was made harder when 'others' did not do the same. None of the mothers I spoke to banned sweetened treats completely which they spoke of being an impossible task even had they wanted to. The younger mothers saw sweet treats as a part of childhood so denying

their child access to such things would have been seen negatively. Most of the older mothers wanted to put stricter controls on their children's consumption of such products but recognised that a complete ban was both unrealistic and potentially leading to greater problems in the future as a result. Catherine's attitude was typical:

But you go to places and they'll be, you know, a smorgasbord and there'll be cocoa pops and then she discovers cocoa pops 'oh god no'. So you can't fully protect them and I think you've got to have a balance because if it's too extreme and they've been feeling deprived of it they'll just go mad at some point, when they see it all, so that's quite a hard one. (Catherine, age 41, 2 children)

Sugar is seen by these mothers as potentially damaging both in terms of health and future dietary habits. It is a risk that they need to 'protect' their children from although this is not easy as being 'too extreme' could lead to even worse future scenarios when access is inevitably gained. The negotiation of access is therefore complex as there are risks both to being too lenient or too strict. Even the younger mothers who saw such foods as part of growing up and being a child, had limits to their tolerance and in order to retain their status as a good mother talked of putting some restrictions on their children. For all the mothers I talked to there was a sense that a mother who allowed total and open access to all sweets would be seen as a bad mother by those around her. Such negotiations require forward thinking, planning, and being constantly aware of what your child has been consuming. One strategy which mothers talked of adopting linked back to their notions of balancing out their child's diet as discussed by Claire and Hilary:

Hilary: And I see that you can sort of make up for that. So if they do have a day or (Claire: well exactly) they eat lots of rubbishy things that you wouldn't necessarily give them, um, you can sort of say, well tomorrow we'll have a really good day. You can balance it up. (Claire, age 40, 1 child; Hilary, age 43, 2 children)

The idea of balancing out a child's diet is a way that mothers talked of retaining overall control over what their children were eating. It was clearly also the case that mothers made decisions over where they went and who they saw such that they made decisions to spend the most time with others who held similar views to themselves on feeding their children. This was the case for both mothers who were more permissive as well as those who were strict. By spending most time with like-minded 'others', mothers were less frequently challenged on what they chose to do and therefore found it easier to display good motherhood through their children's food. Children whose mothers were working spent the most time out of their mothers' direct control. Working mothers talked at length about their childcare arrangements and the ways in which food was negotiated. Paying for childcare services did not automatically give mothers the power to choose what their child ate:

I'm obviously not in a huge amount of control over what he has at nursery, but I'm comfortable with what they're giving. I think that they have quite a varied diet. I think sometimes, you know, they don't have to have cheesy baked potato, bean things every fortnight but, you know, I think nutritionally it's quite a balanced, it's a good thing anyway so that's okay but he has, he has a huge variety of food and he's always balanced out with lots of fruit and veg.
(Sofia, 39, 1 child)

Nursery menus are generally devised by a nutrition expert which all mothers referred to. Through emphasising their knowledge of the nutritional content of the food provided, mothers were able to demonstrate their care and attention to their child's food and, by implication, health, even when they were absent. For some, tensions remained but they were able to reconcile these through specific negotiation with their carer. Like the mothers who reported difficulties retaining control when visiting 'others' it was sweetened foods, provided by nurseries which caused most problems. Although noted as an issue by a number of mothers, two mothers in particular had gone to great lengths to negotiate the provision of pudding and sweet foods with their nursery. This was done despite the knowledge that nursery meals were devised with the input of a nutritionist, were nutritionally balanced and followed current nutritional guidelines:

I've said to the nursery, you know, I don't want *older daughter* to have sweets and puddings, like a lot of the other kids. (Catherine, age 41, 2 children)

They thing they really struggled with was the 'pudding rule'. They couldn't cope with; 'she can have pudding sometimes, but no more than once in a day, and not every day'. This was our rule and certainly she couldn't have cake, and um, but she could have things like rice pudding. As a baby, I mean, she couldn't have things like cake and stuff like that and they did really struggle with that. And then as *older daughter* got older she came through and they said 'it's really difficult, the other children are having it and she knows she's missing out on it' and that's the point where we said, at nursery, okay that's fine. The menus are very balanced, they are

nutritionally balanced, they look at a whole day's worth of food and what they're eating is okay. They're not having ten tons of stuff, so we got to a point there where we just said 'yeah that's fine, you know, you give her what you're giving everybody else with a few minor exceptions and we're really happy with that'.

(Liz, age 36, 2 children)

Both Catherine and Liz were very aware of the nutritional content of the nursery food (their children were at different nurseries), yet they felt they wanted to control the sweet element of their children's diet. Liz talked of having to make compromises between what they would ideally have wanted, a continuation of the 'pudding rule', and the fact that their daughter was in an environment that was essentially out of their control. There was also the social element of eating as the nursery pointed out their daughter had reached a point where she noticed she was not getting the same as everyone else. Although Liz dismissed the nutritional balance of the nursery food when she invoked the 'pudding rule', she then uses it to justify her change of position. Women in Liz and Catherine's position talked of being able to keep control or being able to negotiate control in a way that was absent from the talk of the younger women in my study. The fact these women were paying for childcare gave them some legitimacy over asking for certain dispensations but the fact they were paying was not enough in itself to allow them complete control, it still had to be negotiated.

The Chicken Nugget

Whilst the 'biscuit' represents discourses around food avoidance and issues of control, the 'chicken nugget' represents parenting practices. Intensive mothering was

first written about by Sharon Hays in 1996 when she described the ideology as ‘a gendered model that advises mothers to expend a tremendous amount of time, energy, and money in raising their children’ (Hays, 1996:x). Intensive mothering has come to symbolise the norm or at the least an aspirational norm for many mothers in the current neoliberal society in which we live (Vincent, 2010). The responsibilities of intensive mothering, however, require time and resources that are not equally available to all mothers. Indeed the notion of intensive mothering privileges women with money and a partner with whom to share the responsibilities of parenting, leaving those experiencing poverty, especially single mothers, open to criticism and ultimately being judged as inferior parents (Vincent, 2010; Leigh et al., 2012). Although ideals may be aspired to, Leigh et al. (2012) argue that all parents must make some compromises and decide what is desirable and what is possible.

Whatever form of intensive parenting is deemed possible by individual mothers there is an awareness that actions are being noted and judged in a Foucauldian mechanism of governmentality. Shirani et al. (2012) argues that the scrutinising and judging of mothers’ actions leads mothers to draw on the notion of the ‘other’ to describe those who are doing a worse job and falling short of expectations. The notion of the ‘other’ is in opposition to the reflexive middle class parent who is responsible, self-sufficient and reflexive (Shirani et al., 2012). Although it has been argued that the notion of the intensive mother may be felt more by middle class parents who are more accepting of this as a social norm, Bloomfield et al. (2003) found all mothers, regardless of social background, felt the constant need to compare themselves with ‘others’. Comparisons led both to feelings of guilt on occasion but also the acceptance that being a ‘good enough’ parent was at times the best that they could do (Bloomfield et al., 2003). In relation to cooking for children the ‘chicken nugget’

took the discursive role of representing the uncaring or lazy mother who was not willing to labour for her children in the short term and thus was willing to risk her child's future health.

Mothers from all age groups and social backgrounds eschewed the 'chicken nugget' which they saw as representing children's food and the lack of labour mothers were prepared to invest in providing food for their children. Mothers also equated children's food with frozen food and again the 'chicken nugget' was the common example:

I don't give her, like we don't buy no frozen stuff, like there's never any chicken nuggets or fish fingers in the house so. (Judith, age 21, 1 child)

[partner] ate very traditional food, you know, beef burgers and chips, fish fingers and chips, stuff that still appears on children's menus, you know, the chicken nugget thing but that's not what we subscribe to at all. (Liz, age 36, 2 children)

Although from different age groups and social backgrounds both mothers distance themselves from the types of foods which are associated with lazy uncaring mothering as a way of presenting themselves as good mothers. Liz takes the representation of her good mothering through food choices further by alluding to a conscious philosophy of feeding as something they 'subscribe to'. Both show awareness that to feed your children in that way would be judged harshly. Some mothers not only talked of what they did but also compared their actions to 'others' to further set themselves up as 'good mothers':

Sheila: I remember one mum telling me about her three year old 'oh the only thing he'll eat is chicken nuggets and chips'. Right, well my son's never had chicken nuggets and probably very rarely had chips at the age of three. It's like obviously (Karen: If you don't give it to them) if you had perhaps tried more vegetables then you know they'd have that then but it's more about educating the parents. (Sheila, age 39, 2 children, Karen, age 39, 2 children)

Not only are 'chicken nuggets' inappropriate foods but parents who feed them are judged responsible for their children's overall poor diet. Little thought is given to the reasons why a mother may make the decision to feed such foods to her child. For mothers like Karen and Sheila the 'chicken nugget' is symbolic of mothers who are not willing to put the time and effort into providing their children with a varied diet. Therefore, not only are they positioning themselves as willing to do the extra work required but distancing themselves from these 'others'. This is not just about food preparation but they are not 'giving in' to the provision of 'children's food', again symbolised by the 'chicken nugget'. Some mothers were more explicit in their criticism:

I think there could be more information forced on us as parents of young children, 'cause whereas the likes of me and my friends want to do the best for our children, there's a lot of people out there who can't be bothered or haven't got the information in the first place.

Do you know what I mean? (Beth, age 41, 4 children)

In describing two distinct groups of mothers, those like her and her friends, and 'others', Beth can claim the position of being a 'good' mother and blame lack of

effort or knowledge for the shortcomings of mothers criticised as not wanting the best for their children. Some mothers were much more damning of the ‘others’ who they talked of as making excuses for not preparing healthy food for their families:

Alison: I think, what I get annoyed with, is things on the telly or radio. There was something recently about this person, who said they can’t, they could only afford to give their children processed meals because it’s cheaper. (Karen: no, that annoys me, yeah) And when I hear that, it drives me insane, because I think you can have a baked potato and beans and I think that’s quite a healthy cheapish, well cheap, meal and when they say they’ve got to buy all these processed things because they are cheaper and that’s the only way they can feed their family. That’s just, I think that’s rubbish.

Karen: It is rubbish.

Alison: You can buy bags of pasta for a couple of pounds. It’s the other way round.

Sheila: You can make macaroni cheese with spinach and sweet corn in it in ten minutes from scratch.

Karen: Yeah.

Carol: So why do you think people say, you know, feel like that?

Alison: Because I think they don’t put the effort in, or have the knowledge, or combination of the two. And they just go into the supermarket and they think that the only way to cook is what’s already prepared for them. (Karen: I think they’re lazy) They wouldn’t think of cooking a potato or, so I think they look at, I

don't know, they just look at the cheaper options or that range and that's what they buy. But I think you can eat healthily, like you said, for much less. (Karen, 39, 2 children, Sheila, 39, 2 children, Alison, 30s, 2 children)

Like Beth above, these mothers condemn 'other' mothers' food provisioning choices as lazy and uncaring although they acknowledge the possibility that ignorance could be partially to blame. The mothers who were critical of 'others' and quick to dismiss cost and convenience as valid reasons for not providing healthy food, were all middle classed. Although most mothers made some comparisons to 'others' in an effort to claim good motherhood it was middle class mothers who were vocally critical of others. Mothers like the three friends above defined their own version of healthy family eating as acceptable condemning other interpretations. This is illustrated by their disdain of the use of 'convenience' foods despite talking about those (baked beans and sweet corn) they frequently use themselves. Such distinctions can be understood through the work of Beverley Skeggs. Skeggs (1997) talks about the way middle class women measure themselves against the respectability of 'others'. Notions of respectability are evidenced through housewifery and skills at mothering, which could include food provision (Skeggs, 1997). Mothers who do not make time nor expend the effort required to produce healthy food for their family are therefore judged against the middle class notion of respectability and found wanting. This is seen in the discourse of the friends who claim mothers who resort to processed foods to be lazy, ill informed or just plain ignorant. This discourse also fails to recognise any structural issues which may face mothers who use foods deemed unacceptable for children. Such focussing on blaming those who make these choices rather than understand why their behaviour is that way has also been seen in

discourses around benefits recipients or single mothers whose positions condemn them to the classification of undeserving and somehow to blame for their circumstances (Skeggs, 2004). These middle class mothers saw the ‘other’ mothers at fault in giving such foods to their children and not working harder to give them ‘better’ foods i.e. more vegetables and fewer chips. One of the young mothers I spoke to talked of her dislike of convenience foods but felt she had little choice but to feed them to her son:

Like I say, I prefer it if they ate a home cooked meal like um, I make salmon and mash, *daughter* will eat it but he won’t so then I have to make him...I don’t mind going out of my way to make the extra meal... um it’s crap isn’t it really, frozen chicken nuggets and chips, it’s not good for him. I don’t want him to be unhealthy when he’s older or just living on chicken nuggets and chips. (Sam, age 22, 2 children)

Sam clearly understands her position as good mother is compromised by giving her son ‘chicken nuggets’ but feels she has little choice as her son won’t eat the other food she prepares. Whilst aware of the discourse of irresponsibility she counters the implied accusation that she is lazy, directly stating she is happy to do the work and she also refutes notions of ignorance by linking a future living on such foods as equated with ill health, something she is concerned about. The discursive power of the ‘chicken nugget’ can be expanded to consider wider issues of convenience food seen in opposition to home cooked food made from scratch.

The Ideal of the Home Cooked Meal

If the ‘chicken nugget’ embodies lazy, uncaring mothers, the home cooked meal, made from scratch can be seen as the ideal which is held up as a gold standard. The home cooked meal’s significance links back to intensive mothering ideals where good motherhood lies in the amount of effort exerted in being a parent (Hays, 1996). It is also to be found in the political rhetoric which emphasises the importance of families eating together (which will be explored further in Chapter 6) and the dominant discourse of healthy eating which emphasises the importance of fruit and vegetables and home cooked over processed foods. Definition of home cooked of course varies as some claim the status of a home cooked meal if the meal is assembled at home from a number of ingredients whether or not they are processed (Moisio et al., 2004). What is important is the labour of putting the meal together and through that labour mothers can claim good motherhood. Catherine articulates her definition of feeding her children well, which she describes as ‘the old fashioned way’:

...the kind of meat and three veg, steady meals, no snacking and, um, no sugar and, um, not a lot of additives and preservatives and you can try and have fresh food and that sort of thing. It’s not always possible though. (Catherine, age 41, 2 children)

This definition of food provisioning requires discipline to avoid snacks, sugar and additives, all of which requires labouring from the mother. Most of the mothers talked of their own definition of home cooked which fell someway into this ideal. What was important was the desire to put the needs of their children first along with emphasising their definition of home cooked in whatever form that took. When

discussing how this was achieved alongside balancing all the many priorities that mothers had, the ideal was negotiated and strived for although most also noted, like Catherine above, that the ideal was not always achieved. Retaining an ideal, even when it was not always possible to attain, was important to mothers' sense of self as a good mother. Good mothers strive to provide home cooked meals every evening and those who do so most of the time are to be admired. This ideal was talked of by all mothers regardless of age and social class albeit that there were differences in definition of home cooked. Differences in definition may have existed but there was a consensus that good mothers were those who provided home cooked meals most of the time, even those who could not live up to that ideal could still claim good motherhood through acknowledging the ideal and showing they were striving to achieve it.

Although this study focused on mothers with children over one year of age, many mothers discussed how they first introduced solid food into their child's diet along with issues or problems they faced. Just as the 'chicken nugget' epitomized the uncaring mother for children over the weaning period, pre-prepared or 'jarred' food had the same discursive role in discussions of feeding babies. Mothers' accounts of weaning their children focussed on their strategies, whether it was pureed food or baby-led weaning with most emphasising how they had spent time making the food themselves, from scratch. Just as the ideal of the home cooked meal relied on women's labour, the ideal of baby food revolved around home made with mothers who relied on pre-prepared or 'jarred' foods seen as inferior. Mothers were willing to say that the ideal was not always possible but admitted to the use of 'jarred' foods most often when they were 'out and about' or travelling. One mother was happy to talk about how she used 'jarred' commercial products as her primary source of food

for her baby. Interviewed with her friend, Rachel talked at length of her disdain for authority and being told what to do. She privileged her mother and best friend over all other sources of information and advice. Talking about how she fed her son she said: 'if anything it was the jar foods at ASDA. They are just quick and easy' (Rachel, age 19, one child). Rachel clearly eschewed the ideal of the home cooked meal or the need to labour as a way to claim good motherhood. Having stated that she considered the current government emphasis on dietary guidelines to have gone 'too far' and that you should be allowed to follow both your instincts and how you were brought up, she did have rules that she imposed on her son:

We like to make sure he tries to eat half before he has a pudding
 'cause I don't want him to grow up thinking oh I'll only have a
 little bit and then mummy will give me yoghurt and chocolate
 whatever I want sort of thing but he's not really fussed if he has
 chocolate or not. He hasn't got a sweet tooth. (Rachel, age 19, one
 child)

Not only is she showing that she is willing to impose rules but that she is conforming to the social norm of savoury before sweet. It was important for Rachel to show she was a caring mothers and she did go on to talk about how she and her partner ate with their son every evening and that she did cook some meals. It was important for Rachel to claim good motherhood, which was done through prioritising her son's happiness:

Just their health obviously and making sure you've got the money
 to spoil them. That's all I care about. As long as my child is happy

I'm happy. If that means he has a chocolate bar and a Macdonald's
for lunch then so be it. (Rachel, age 19, 1 child)

None of the mothers I spoke to were willing to renounce good motherhood although there were variations on how it was claimed. To do so would run too great a risk of being labelled a bad mother, something no mother seeks. Allowing children access to fast food divides mothers in their views of acceptable parenting and notions of good motherhood. *McDonald's* is the iconic fast food brand and was mentioned by many mothers both in positive terms, as a treat, or negative as an 'unsuitable' food to feed children.

***McDonald's*: fast food icon**

During the interviews mothers often talked about very particular food types or branded products that they particularly avoided, restricted the intake of, or which they talked of as symbols of bad parenting. There were clear differences between mothers in how they defined foods and dealt with their consumption. Fast food, epitomised by *MacDonald's*, was the most often mentioned and garnered opposing views. Mothers either saw *MacDonald's* as the epitome of 'bad' food which they would avoid at all cost, or they saw it as something which could be incorporated into a healthy diet as long as restrictions were in place. Middle class mothers were unanimous in their dislike of *McDonald's*, with many parents proudly telling how few times, if ever, their children had been to a *McDonald's*:

I think in all the years I think she's had one or two *McDonald's*.
(Lynne, age 39, 2 children)

We've never been to anywhere like *McDonald's* or (Karen: No my children have never had any) I don't want them to for as long as I can help it. (Sheila, age 39, 2 children, Karen, age 39, 2 children)

In this discourse mothers not only wanted to avoid such foods but saw *McDonald's* as symbolic of a lifestyle that they did not want to follow. In addition to wanting to avoid such places for your own children, some mothers openly criticized other parents for giving such foods to their children:

I see two year olds being fed *McDonald's* in town and I think 'God how can they do that to their children?', unless they are really desperate for something but you know.... (Marissa, age 35, one child)

Framing parents who feed their children *McDonald's* as having to be 'desperate' for this to be a reasonable course of action was a particularly middle class attitude:

I think when I first had a six month old first child I thought there definitely were rights and wrongs and now I don't think that at all, I think most people who are reasonable parents, you know, feed their children reasonable food and that's okay, um. I think, the things I think are a wrong way, if I'm to put it that way, is fast food and junk food and you know. So we don't eat out in places like *McDonald's*, I would never let the children eat that sort of food. But we do eat out quite a lot but I suppose we are quite selective about where, what we eat and where we eat out. So as I say, junk food I suppose is off my list of reasonable foods to give children, but beyond that I think it's all fair game because I think we've got

to be part of the real world, they're going to go to school, they're going to become adults, they've got to learn to make choices. (Liz, age 36, 2 children)

McDonald's discursively embodies bad parenting for these middle class mothers. It is not only that the food is not what they would want to feed their children but also that it represents 'unreasonable' foods to feed children. Avoiding such food outlets middle class mothers are furthermore trying to confer their children with tastes for particular foods. Through their available economic capital, middle class mothers are able to distance themselves from the food choices of working class families and show their distinction in this way (Bourdieu, 1984). It is not only taste and distinction that are important to these mothers as they are keeping a critical eye on what others are doing and judging them for their choices. Furthermore these mothers reason that avoiding taking their children to *McDonald's* now will be important for their future as they are avoiding creating the taste for such foods which, if dominant in dietary choices could lead to health problems in adulthood.

Working class mothers were more pragmatic about fast food generally and *McDonald's* in particular:

He generally has a healthy breakfast and a healthy lunch and, um, and also a good home made dinner. So, I don't worry about him having a *McDonald's* every now and again or, you know, if he wants sausage and chips on a Friday it's not a problem. (Emma, age 35, 3 children)

For these mothers *McDonald's* represented a treat whether it was weekly with a grandparent or occasionally with a parent. It is also seen as part of a healthy balance

that is justified through paying attention to the content of the meals that went before or would come after. Negotiating good motherhood for these mothers is done through emphasising the pleasure and enjoyment that their children gain from eating at *McDonald's*. The social element of treats with grandparents or parents was important to these mothers therefore, as an affordable place to eat, *McDonald's* is not condemned by them. The friends Rachel and Polly, who were discussed above in relation to using convenience foods, deliberately used *McDonald's* as a symbol of their right to feed their children how they wanted. Using the symbols of a chocolate bar and *McDonald's*, in the quote above, could be seen as a deliberate challenge to the social norms that these mothers saw represented by myself and the children's centre they were visiting at the time of the interview. These mothers were aware that their attitudes, including regularly 'treating' her son to *McDonald's*, could be viewed negatively:

Rachel: If I'm in *McDonald's* then he'll have a *McDonald's*, can't wait for her to get teeth and she can have a *McDonald's* as well.

Polly: yeah I just find it, if people don't like what I'm giving her then (Rachel: don't look) exactly it's not their child at the end of the day it's mine. (Rachel, age 19, one child; Polly, age 22, one child)

In talking about looking forward to feeding Polly's baby, who was 5 months old, *McDonald's* they are stating they are going against what 'others' would be considered acceptable feeding behaviour. Although they are claiming not to care, their observation that 'others' may look at them disapprovingly shows they are aware of the surveillance of 'others' and the expected self-regulation, which should prevent them feeding their very young children *McDonald's*. These mothers were happy to

eschew the social norms but simultaneously they worked hard to claim their own versions of good motherhood. Whilst presenting themselves as willing to go against some feeding norms they emphasised the importance of their children being healthy and happy and that they wanted to be able to give their children what they wanted.

Food Risks the Case of ‘The Egg’

In discussing good food in opposition to bad food the discussion has centred around notions of balanced diet, appropriate foods to feed children and the need to develop a taste for healthy food to ensure good health in the future. I now want to turn to food borne risks and to consider whether what relevance they have for the mothers in my study. As discussed previously theorists including Beck (1992) and Giddens (1991) contend that we live in a risk society which is the result of increasing modernity. Beck argues that late modernity is characterised by the increased scientization of risk whereby individuals are increasingly called upon to make decisions on risk but are more reliant on ‘experts’ to make the risk assessments for them (Beck, 1992). In relation to the food system Green et al. (2003) have shown that, as consumers rely on experts to tell them when something is wrong, they trust the system until informed otherwise. As the modern food system is further complicated by the use of new technologies (for example genetic modification) individual consumers have ever greater difficulty in making risk assessments (Dowler et al., 2006). As outside information is relied on trust in the source of information becomes more important. Work by Draper and Green (2002) showed that in the UK politicians and policy makers are not trusted which they suggested could be a legacy issue following the handling of the BSE (Bovine spongiform encephalopathy) in the 1980s.

The media has an important role to play in the reporting of food safety issues, especially when there is a health risk, for example, when a particular product needs to be recalled. Furthermore, the media reports on a great number of food and health stories, from wider health issues relating to eating, to animal welfare stories. This section explores the extent that the women I talked to were aware of media reporting on food safety issues, and whether it had an impact on shopping and eating habits, in both the long and short term. A number of mothers reported that they hadn't been influenced by the media and couldn't recall any stories that affected either their shopping or what they ate, or fed their children. For those who could recall media stories about food, the most often cited were stories focussing on eggs and salmonella, although none mentioned Edwina Currie (a Conservative MP) who had sparked a controversy about eggs in the 1980s. In response to being asked if she notices anything about food or food scares in the media one of the young mothers Judith talked more generally about foods then specifically about eggs:

Yeah I do sometimes, but I don't think the shops wouldn't sell it if it was bad. I think, I think they'd take it off the shelves straight away so. Salmonella's quite a bit one with me, I make sure my eggs are cooked properly.

When asked where her knowledge on salmonella has come from she continued:

I think that's just in general like knowing that if you don't cook eggs properly you can get salmonella from it. I think it's just that.
(Judith, age 21, one child)

Judith was not alone in stating that supermarkets would not knowingly sell food that was unsafe. It could be argued that mothers, like Judith, need to feel trust in

supermarkets as the alternative is too difficult to manage. Risks from eggs are different as there had been no media stories on eggs in the months before the interview and as Judith pointed out cooking eggs ‘properly’ was considered common knowledge. This illustrates the way in which a food risk becomes embedded in behaviour as Judith, along with many of the mothers interviewed, was too young to remember the egg crisis on the 1980s. Sue also mentioned mistrust of eggs, amongst a number of things she recalled from media stories:

Oh like the beef, you know, mad cows, you know, I wouldn’t buy that and I, there was all glass in the baby jars wasn’t there once, but I didn’t buy jars anyway ‘cause they’re no good are they? But no, if I saw something, like eggs, years ago I would have ate the cake mixture, I wouldn’t now. (Sue, age 43, 3 children)

In this exchange Sue shows all the food issues she has been aware of recently and wants to represent herself as knowledgeable, and a good mother by not taking risks. Her status as a ‘good mother’ is further enhanced by her claim not to use ‘jars’ which are ‘not good’. Sue, like Judith, was unsure where her specific knowledge had come from, but she was sure that she wouldn’t allow her young daughter to eat cake mixture containing raw eggs:

Oh no, I wouldn’t do it either now, so. Even though I know it tastes good, I would never let her do it, I wouldn’t let her, you know, so. But I obviously wouldn’t do that now ‘cause you just never know do you really so, and obviously, I’m very careful with food like preparing food, all the meat and all that lot. (Sue, age 43, 3 children)

It was the uncertainty of knowing whether there would be any problems with eggs, which concerned Sue, and that uncertainty meant it was not worth taking the risk. For one young mother the risk was such that, since a particular story about eggs in the media, her family had not eaten eggs:

Um, there was a thing with the eggs a couple of years ago when they had that bad batch of eggs and I haven't had eggs since *laughs*. Yeah, but I get a bit panicky like that, you know, if I hear something 'oh you can't eat that', you know, a bit like the mad cow disease you can't have nothing to do that, you know. My Mum was saying 'yeah, it's there it's all the time, it's there it's not just...' but no we haven't had eggs since and we're fine. (Lorna, age 25, 3 children)

Although she could not recall the exact egg story, taking the risk of eating eggs was too much for Lorna. However, she also talked of baking cakes with her daughters so it unclear whether she used eggs in cooking and thus saw the risks associated with eggs in that circumstance differently. For all these mothers eggs pose a general threat that is always there and not considered worth risking their or their child's health over. Risks in this instance can be ameliorated by cooking eggs properly and not eating raw eggs therefore, they can be controlled.

Whilst eggs represent a change in behaviour that persisted over a long term, short-term changes in reaction to media stories were also discussed. A number of mothers recalled a food scare in the previous year when European cucumbers were infected with e-coli. Natasha's reaction was typical of those mothers who mentioned the incident:

Like in the instance of the cucumbers, um, I would, I kept an ear open for any information and then I continued that, because I followed it at home, the news. I didn't make any particular steps to follow it and somehow it resolved itself and then I waited and they didn't report anything else. I think we didn't eat cucumbers for about a month, a month and a half, something like this, and then it was fine. Plus we don't eat just cucumbers, isn't it so? (Natasha, age 33, 2 children)

Experts, reporting on the news, are relied upon to inform consumers that cucumbers are infected but they are not used specifically to say they are now safe. In this instance, it is a lack of news that is used as an indicator the risk has passed and the food system is once again safe. Cucumbers are a particularly easy product to avoid, therefore it is an easy decision to stop eating them whilst a risk is perceived. With no independent means of verifying the safety of cucumbers consumers have little choice but to trust the system and resume consumption after a period. Mothers did not talk of food risks as being something either constantly on their minds or something that they worried about even when issues, like cucumbers, were brought to their attention. With all the many things they thought about in trying to feed their children, according to their version of healthy eating whilst also providing an enjoyable experience, food safety risks were really not considered a priority. This is supported by the fact that most mothers could not recall any particular incident or were only after prompting about whether they had heard a story last year. The same was not true of the broader risks of not adhering to guidelines on weaning children. Many mothers talked of being aware of which food to introduce, or more specifically

to avoid, until very specific ages had been reached. These risks were seen as pertinent and potentially more damaging to their children.

Risks from Not Following Guidelines

Many of the mothers recalled two specific areas of guidance when their babies were under one year old. The first was the age at which solid food should be introduced and the second which foods should be introduced at which age. Early introduction of some foods carries health risks that are clearly laid out in the information mothers receive. Most mothers could recall getting information on what to feed at what age although their reactions to that information differed. Some mothers saw the information as a directive as described by Catherine:

What I remember from those was not so much what you could have but definitely what you couldn't have at different stages. Made it very clear about peanuts, and honey, and eggs, and when to introduce different things. I think I followed that quite closely, yeah, because it was very clear on the handouts. (Catherine, age 41, 2 children)

The risks related to the introduction of foods at specific ages (from risk of botulism in honey to allergy or choking in peanuts) are calculated by experts and conveyed to parents (mothers). Mothers then have a clear choice, to adhere to the advice of the experts, like Catherine, or to consider the risk and make an alternative decision.

Having the list was helpful to a number of mothers as a guide, but some deviated from it as they felt their knowledge was sufficient to counter the risk claims of experts. Sheila runs a deli with her husband and has a catering degree therefore,

she was confident in her knowledge of food and food related risk. She also recalled being asked by the deli customers what they could eat when she was working and pregnant:

We own a deli, we sell a lot of unpasteurised cheese and stuff. I didn't eat unpasteurised cheese but I would eat, I had far more.. People would come in and say, customers would ask questions as well about 'oh I'm pregnant can I eat this can I eat that?' And I'd be like 'well no you can't eat this but you can eat this and also you can eat things like stilton if it's cooked' and stuff like that so I guess I was braver than a lot of people because I've quite a good knowledge of it, about stuff like that. And now they've eaten, well like *Crunchy Nut Cornflakes*, I remember you being quite shocked that I'd given *older daughter* them (Karen: well *son* has them now) yeah, but I mean *older daughter* was having then quite early because *husband* eats them and I hadn't really, whereas you didn't give anything to *son* did you? (Sheila, age 39, 2 children, Karen, age 39, 2 children)

In describing what she did Sheila stumbled over how to phrase her actions saying 'I would eat, I had far more' showing that she was not entirely clear on the best way to articulate her deviance from the heavily prescribed list of foods to avoid (in this case during pregnancy). By stating that she 'didn't eat unpasteurised cheese' she is also making clear she knew where to draw the line in her interpretation of the rules, thereby showing she was clear she wouldn't risk her unborn baby's health. However, the word 'braver' indicates that to break from prescribed action was not an easy decision; albeit one that she had confidence in, through her knowledge of food and

catering. It also shows that she was aware that she was taking some risk in not following the rules rigidly when pregnant. In the discussion of *Crunchy Nut Cornflakes*, Sheila talks of ‘shocking’ her friend by giving them to her daughter before nut introduction was recommended and nearly admits to not having given it much thought but shies away from that by moving on to talk about her friend’s position of rigidly adhering to the rules. This discussion illustrates the risks to their self-identity as ‘good’ mothers, women face if they flout health advice that can be ameliorated by justification of their actions.

Weighing up the risk is something that mothers do constantly and often consciously as described by Lesley when she decided to give her son peanut butter for the first time:

Um, they didn’t talk about nuts but I was kind of a little bit sneaky with nuts in that I gave him things like peanut butter and things like that, not because, but because I wanted to see whether there was a problem early on and I wanted to be in control of it and know it was happening. And I also felt, as well, there was no kind of allergy within the family so I sort of felt that the chances were that he would be fine. I think if there had been an allergy within the family, I would have been a little bit more, I probably wouldn’t have been as brave and waited to have done it. But I kind of was pretty convinced that he would be fine so we went for it. (Lesley, age 41, one child)

Although Lesley mentions that ‘they’, her health visitors, did not mention nuts she was aware that there is government advice on the introduction of peanuts. She is able

to retain her identity as a good mother by demonstrating the amount of thought she had given to her decision and further justifying her position by stating there was no allergy in the family therefore the risk is reduced. None of the mothers were willing to dismiss 'expertise' out of hand. They all used some version of expert knowledge to justify their position showing the power of the expert even when their advice is only partially followed.

Looking at the age at which foods should be introduced most of the middle class women spoke of adhering to the guidelines as much as possible with few exceptions. Young, working class mothers spoke more often about introducing foods before the recommended six months. This was not done through a lack of knowledge or understanding but because they had taken a conscious decision that they were moving on to the next stage and with good reason. Many spoke of being 'told off' by health professionals for weaning too early:

Eve: Well I hadn't started and I was like 'he looks like he wants to do it' and she [health visitor] was like 'keep him on bottles for as long as possible' and then I just thought he's not having any of this. You know your own kid.

Zoe: The thing is, the health visitors don't really know a lot because every baby is different. No one baby is the same and, you know, one baby can go until he's six months with no food but then some babies, you know, are quite hungry and they want more and you just know, if it's your child, you know, like, you know what your child wants. If you know he wants food then you're going to give it to him, you can't not give your child food. (Eve, age 17, 1 child, Zoe, age 19, 1 child)

For these young mothers experiential knowledge relating to their child was a key decision making factor in early weaning. Denying a child food was unthinkable for these mothers and this argument is used as a powerful defence of their actions. These mothers saw no health risk in weaning early but saw a moral risk in failing to give a child food. This group of young mothers were also very clear that when their child was ready, the decision to wean, even if it was before the recommended stage, was easy to make. Risks were dismissed as was professional expertise to some degree. These women called on their own experiential knowledge along with their own mothers' knowledge and their upbringing as evidence that no harm had been done by weaning earlier than six months. In the face of going against recommendations these mothers negotiated 'good motherhood' through paying attention to their individual children and claiming alternative expertise.

Conclusions

This chapter has described how foods and feeding strategies can be seen in opposition to one another. Whether it is sweet foods, fruit and vegetables, processed or fast foods mothers were all aware of the status such foods occupy in social norms and took a position on them. Foods like 'the biscuit' or 'the chicken nugget' have strong discursive power and indicate a much wider feeding strategy that is symbolised by the food alone.

Symbols of good and bad food and food decision-making strategies are discussed using 'others' against whom mothers measure and judge themselves. 'Others' are an important way that mothers can feel good about their own food decision-making and claim a moral self even when their ideals are not matched all of the times.

Negotiation of good motherhood is complex as mothers work hard to balance issues of control against pleasure in eating or permissiveness against moderation. Furthermore, mothers have to contend with intensive motherhood ideals which demand they put their children first and work hard in their mothering. In practice, this means cooking daily, preferably from scratch and avoiding processed foods. Additionally mothers are faced with issues of risk which the mothers here see far more in terms of the moral risk of not doing the right thing than in specific health risk attached to individual foods.

All mothers negotiated their versions of good motherhood through defining the things that were important to them. For middle class mothers this revolved around setting up good feeding strategies to ensure the best future health for their children through developing tastes for foods that they considered would be beneficial to this process. Working class mothers also thought ahead and similarly wanted to develop good eating habits in their children but were less likely to talk about foods they never allowed their children to eat rather talking of moderation and fitting everything, even *MacDonald's*, into a balanced approach to eating. How mothers dealt with 'the biscuit' or 'the chicken nugget' was in the end of less importance than their ability to justify their decision in claiming their version of good motherhood. Negotiating the social elements of eating were touched on in this chapter but the importance of the ideal of the family meal and the sociality of eating will now be developed in Chapter 6.

Chapter 6: The Family Meal as Ideal

Previous chapters have considered how the mothers in this study viewed health and the role food plays within this, issues of expertise and the ways in which experts are defined and taken account of and the specific discursive roles of different foods and feeding strategies. This chapter will address family eating, focussing on the discursive power of ‘the family meal’ as an ideal. Through consideration of the ideal of ‘the family meal’, it will explore issues of food as sociality, gendered care giving and women’s role within the family. Examining how mothers negotiate good motherhood through responses to feeding ideals and challenges, it will consider the role of class in the different responses found.

In relation to the ideal of the family meal and how that should be constituted, many researchers have shown women are the ones who generally take on the responsibility with the ideal centring around a home cooked meal, made from scratch and enjoyed together (Madden and Chamberlain, 2010; Slater et al., 2011; Stead et al., 2004; Moisio et al., 2004). Whilst ideals are hard to live up to all of the time, Moisio et al. (2004) show that mothers work to keep the idealised family meal through judicious use of pre-prepared foods which are then transformed through their labour at home. This is just one way in which mothers can negotiate good motherhood whilst taking account of external constraints.

The Family Meal as Ideal

All of the mothers in this study identified with the ideal of family eating, talking about elements of this ideal that they wanted to meet. Current political discourses emphasise the importance of eating together as a family, which is credited with numerous positives from maintaining family cohesion to obesity prevention.

Such rhetoric is well known by mothers, all of whom talked of eating with their children, particularly the evening meal, whenever possible. Whilst eating with their children was considered important as a way of modelling behaviour, mothers differentiated between different meals. It was considered acceptable to feed children breakfast and lunch without eating it with them, as mothers talked of being busy at that time doing other things, from getting ready for work in the morning to sorting out domestic chores at lunchtime. The evening meal held different significance for many mothers who prioritised the time to sit together and make time for family. Mothers of all ages and social groups discursively used the evening meal as a symbol of being a family. Family meals took a variety of forms, however, depending on the composition of the family and the circumstances in which the families were living. Some talked of the importance of waiting for their partner to come home to allow the 'family' to eat together, even when this meant keeping their children out of bed later than would be expected, or of eating different meals but at the same time. Others lacked a dining table where the family could sit together but talked of eating in the same physical space whether some were at the table and some on the sofa. All were articulating their form of being a family, using the evening meal as a focus for this display. For those whom could not all eat together during the week, usually because a partner was late in returning from work or worked shifts, the weekend and Sunday dinner or lunch became the focus of family eating. Moisio et al. (2004) identified the construction of family identity through the consumption of food, particularly homemade, opposing the individualisation of eating they showed that homemade meals were used to revitalise the ideal of family eating. Although their study looked at the differential importance of homemade across different age groups, they did not reveal any socio-economic information (Moisio et al., 2004). Those in

their middle age were most affected by the discourses of homemade and family eating which would correspond with bringing up children and like my study used the production and consumption of food as display of family identity. James et al. (2009) also found the iconic nature of the family meal persists as a symbol of family life. Studying families from all social groups they found family meals central to ‘doing family’, irrespective of whether they took place around a table or on the sofa. Of greatest importance was the togetherness that commensality brings, which the mothers in my study echoed.

In addition to displaying family through eating together, middle class mothers additionally aspired to a particular ideal of family eating which crucially included conversing around the dining table. They talked of their constant struggle to get small children to sit down together for any length of time. It was a challenge to find times when all the family could practically eat together, let alone eat food that they all enjoyed. These mothers felt it was important to persevere because all their hard work was going to pay off eventually, and although it may be painful now, they would be rewarded in the future:

Our theory is that we’re laying the foundations *laughs*. We’re often looking at each other going ‘well that went well’ when one’s in tears and we spent the whole meal getting up and down. But our theory is that, at least they know that’s kind of what we do, and that someday they will be able to have conversations around the table. (Geraldine, age 37, 3 children)

Only middle class mothers spoke of the future desire to have ‘conversations’ as part of the family meal and this indicates an aspiration to cultivate a particular kind of

family. This desire speaks of class distinction whereby accumulation of cultural and symbolic capital would enable these families to converse in a way that sets them apart from others. It relates directly to Bourdieu's (1984) notion of distinction whereby these mothers display particular desires for a future meal experience that signifies the reproduction of their class position. Mothers often spoke of aspects of their own family lives and upbringing that they wanted to emulate in their own families. For many this was the reproduction of the family meal, showing how habitus and capital produce 'lifestyles' that are developed through socialization over a long period of time, irrespective of age or social position.

Food as Sociality

Enjoyment

Although most mothers held up some construction of the family meal as an ideal they wanted to achieve, there was acknowledgement that meal times are often fraught. Part of the expectation of good motherhood is the provision of food, cooked from scratch and critically enjoyed by all. The expectation of cooking from scratch is discussed in Chapter 5 so I will now consider the importance for mothers of their children enjoying the food that they provide. Children's enjoyment of their food was expressed as a crucial element of mothers' own enjoyment of feeding their family. However, feeling compelled to produce food that their children enjoy loads additional pressure on mothers. The social norms of good motherhood require mothers to raise children who not only eat the right foods and make the right independent choices about what to eat, but also enjoy food and the whole experience of eating, a pressure expressed by Hayley:

I'd like *youngest daughter* to be excited about food, like sit down 'wow, yummy, this is lovely I want to eat it'. I kind of want her to have that, like when I was weaning her she used to cry because I couldn't get the food in quick enough and it was so satisfying as I thought 'I've made that and she's enjoying it' and that's how I feel about food. I don't cry in two mouthfuls, but I love food I really enjoy it, um, and I'd just love her to be excited about saying I'd made a whatever, I don't know, I made a casserole or something I made, you know, pasta or something rather than 'oh right' grazing, pushing it round the plate doing an aeroplane that's what I think I would like. (Hayley, age 35, 3 children)

In describing her ideal mealtime, Hayley demonstrates the power that children exert over their mothers' feelings of self worth. This was a powerful discourse with many mothers describing how they felt when their child ate or rejected food. Mothers' accounts of rejection were strongest when their child rejects food that they prepared, describing frustration when their child rejected something they had put effort into preparing. If good motherhood is negotiated through efforts made in relation to family feeding, greater effort, through cooking from scratch, gives greater reward but concomitantly can lead to greater rejection. Only middle class mothers, like Hayley, talked of their own enjoyment of food and wishing to instil this in their children. Some mothers talked of the importance of food and mealtimes being fun and these mothers were more likely to be younger and working class. Emily talked about what was most important to her in feeding her children:

Their health, their enjoyment of food because I always think that food should be fun, food needs to be fun sometimes to encourage

children to eat, experimenting with different foods, different textures, different tastes, um, but it's mainly that they're happy and healthy with what they're eating and what they're getting. (Emily, age 26, 2 children)

Good motherhood for Emily is negotiated through giving her children variety and fun, ensuring their health and happiness. When children are eating what they are given, mothers feel good about themselves and if children then express pleasure and joy whilst eating this is a true affirmation of self as good mother. Joanne talked of the importance of her son's pleasure in eating (see page 97) but crucially whilst seeing his enjoyment as 'the main point' she still feels the need to position this within the important health discourse:

That's the main point and of course as long as they are eating healthily and gaining weight but you just want 'em to enjoy what they're doing. (Joanne, age 28, 2 children)

The presentation of herself as a good mother required Joanne to articulate the importance of health as well as pleasure as good mothers would not sacrifice health for pleasure.

This research highlights the power that children were shown to exert over their mothers' view of themselves. When things are going well mothers talked of experiencing powerful positive emotions as articulated by Marisa:

The most important is, I think, when she's eating well and it makes me happy, um. Now she is starting to talk and when she likes something she says 'nice, wow' and it is the best things for me that

I can hear and then she eat it and has an empty plate and asks for more, I think, you know, it is the happiest moment for me. (Marisa, age 35, one child)

Mothers, like Marisa, accept the responsibility for their children gaining pleasure from eating almost without question, although their strategies for achieving it may differ. Such positive feelings are experienced in the knowledge that it may be transient. When things are not going well mothers both accept responsibility and experience feelings of great anxiety. Knowing that children change in their eating patterns and food preferences without warning leaves mothers expecting that there will be periods where they experience the doubts and anxieties of having their food rejected:

You know when she eats well it's fine, but if something happens she didn't eat 'oh it's my cooking maybe, or it is something she doesn't like, or maybe she doesn't feel well or' so something like this so always you can find some, you know, case to worry. (Katya, age 37, one child)

Katya never questioned her responsibility for providing foods that her daughter would enjoy and accepted the blame should food be rejected. Even when things are going well mothers, like Katya, are looking towards the next problem or challenge, indicating the constant nature of responsibility. Not all mothers felt this as a constant pressure, although most talked of thinking about food and feeding their children as a constant activity. This leaves mothers caught between the competing demands of providing nutritious food and giving their children a pleasant meal experience comprising of foods they will enjoy. Madden and Chamberlain (2010:297) suggest

that ‘women are positioned within a contradictory, complex discursive space’. On the one hand, they are aware of the need to present themselves as moral selves by providing nutritious foods for their children whilst on the other they want to treat children to pleasurable foods, including chocolate and sugar, the provision of which would render them as bad mothers (Madden and Chamberlain, 2010). These contradictions are not easy to negotiate but mothers do so through alternating between different discursive positions allowing both the giving of pleasure through some foods and the conveying of health through others.

Manners

Mothers assumed a great deal of responsibility for providing family meal experiences that met expectations of nutrition, health and enjoyment. Much of the discussion was around current feeding challenges or triumphs and reflections on weaning experiences. Socialisation of their children was important for many mothers both in the present and for the future, such that they know how to conform to social norms, including sitting around the dinner table and eating the food that is offered, whether at home or elsewhere. This goal was articulated by mothers of all ages and social circumstances and centres on the desire for children to fit in to social groups. Two mothers I interviewed together at a children’s centre talked of their disinterest in the nutritional value of their children’s diet, claiming resistance to the claim that diet is important to health. They negotiated their versions of good motherhood through the desire to make their children happy and were extremely wary of advice on feeding their children, claiming experiential knowledge was all they needed. When the discussion moved to what they wanted for their children in the future, in relation to food, however, they talked of the importance of manners:

Polly: Have table manners (Rachel: yeah) I really want her to have table manners I can't stand these kids that sit there and just don't have any table manners what so ever.

Rachel: I want him to have table manners and I want him to respect food when he goes into school and stuff. (Polly, age 22, one child, Rachel, age 19, one child)

Polly further expressed the importance to her of her daughter growing up to know how to behave in social situations:

I just don't want her, like, say if like she gets in a group of friends or something and she goes and then she's like 'oh I don't like that' 'cause then I'd feel really embarrassed I'd be like 'well you know if you don't like it you just sit there and you eat it and be polite'.
(Polly, age 22, one child)

By comparing their children's future to 'others' who show a lack of respect these mothers show a desire for their children to be accepted and fit in. Polly and Rachel are young mothers and are countering the social stereotype that positions young mothers as feckless, bringing up children who have no respect for others or authority (Kirkman et al., 2001; Tyler, 2013). Although these two friends talked of being disinterested in the health aspects of feeding their children, they were still positioning themselves as 'good mothers' in relation to conforming to social norms around food. Another paired interview with two middle class mothers showed they shared the discourse around the importance of the social norms of eating:

Hilary: And the social side of it as well. (Claire: yeah, oh yeah)

Eating in that, um, at the table 'cause (Claire: at the table) I mean it's quite interesting that *daughter* at nursery will sit down at the table and eat but at home she just definitely faffs and that is perhaps us, we should, in that she'll get up and go off and do something, come back and so, um. (Hilary, age 43, 2 children, Claire, age 49, one child)

Despite differing in their views of the importance of nutrition to health, all four mothers are negotiating good motherhood through emphasising the importance of adherence to social norms. Social acceptance was a strong discourse for many mothers and related both to acceptance of themselves as good mothers and to the acceptance of their child within their peer group. Building awareness of good manners is a way of developing social capital for these children but it also signifies the awareness that mothers feel they will be judged by 'others' on the basis of their child's adherence to the social norms of eating at a table, using cutlery and eating what is presented to you.

Social judgement of others

Awareness of the gaze of others was discussed in Chapter 4 where I argued that mothers feel judged both by peers and those in different social groups. Although middle class mothers talked of an awareness of what they were doing in relation to their peers and talked of the ways 'others' feed their children as a way to feel good about what they were doing, overall they felt confident about their dietary choices. Some young mothers talked of feeling directly judged by 'others', regardless of whether anything was ever said. Being judged made some mothers question

themselves and their decision-making and was felt as a real challenge to their representation of good motherhood. The power of the judgement of others is demonstrated by the way Vicky talks of her experience of giving her daughter a birthday party:

I felt bad, um, on *daughter's* third birthday party because I'd made her all this food and everything. And there was these children that weren't allowed crisps and they weren't allowed, um, sweets or cakes or anything like that. And I'd obviously put this all out and I, um, when that kind of thing happens it makes me feel guilty because I feel like, should I be letting my daughter eat these kinds of foods when other parents are very particular and don't let their children, you know, they are forbidden from eating biscuits or anything. (Vicky, age 22, one child)

Vicky had talked of attending playgroups with what she described as 'older, middle class mothers'. She thought they looked down on her for not breastfeeding for six months although she knew little about their breastfeeding practices. Vicky's moral position was challenged by the reaction of 'other' mothers at her daughter's party and she worked hard to regain this by listing the fruits her daughter loves and her strategies of not routinely buying such foods. A number of different factors, which are important in negotiating good motherhood, intersect at the event of this birthday party. Being a good mother includes celebrating events like birthdays and being a young, working class, mother Vicky is showing she can provide for her daughter and is a caring mother through giving a party. Food is important at such events too and the provision of sweet foods represents Vicky's notion of childhood and the occasion of a specific event or treats. Feeling guilty stems from Vicky's knowledge that sweet

food should be limited in her daughter's diet and the challenge to her parenting brought by parents who, even at the occasion of a birthday party, would not allow their children to eat these foods. This example demonstrates the complexity of feeding children and negotiating good motherhood through food. Vicky is risking her moral self by providing these foods, showing her awareness of the surveillance and judgement of others over her choice of foods and showing her class position through her judgement of taste in the provision of the foods she chose.

Future Food

Mothers negotiated the production of the family meal, taking account of manners, taste and enjoyment considering both current challenges and looking to the future through the establishment of routines and manners. Thinking of their children starting school (sometime within the following four years), mothers talked of how they would like to see their children deal with food in that context. Mothers took one of two broad discursive positions; either wanting to see their child making the 'right choices' when selecting school dinners or wanting them to be able to fit in by eating what was presented to them. Middle class parents have been characterised as forward looking, investing in their children's future, whereas working class parents have been characterised as dealing with the every day and equipping their children to deal with what their daily lives will entail (Gillies, 2005; Vincent and Ball, 2007; Lareau, 2011). Those who took the first discursive position, wanting their children to make the 'right choices' in terms of healthy eating, were middle class. It was important to them that the foundations for healthy eating were established as early as possible, and these mothers hoped that this would be enough to allow their children to continue on the path of healthy eating, making the right choice regardless of what others were doing around them. Mothers taking this discursive position assume that

‘other’ children will not have been brought up with the same standards therefore, the world away from their maternal influence was regarded as a threat to their nutrition standards. These mothers did not voice concerns that their children would choose unhealthy options at school because they wanted a change from what they experienced at home or that they would prefer the taste of such foods, rather it was the influence of ‘others’ which was seen as potentially problematic. Amy took this position with regard to her son:

I’m really hoping that he doesn’t end up being fussy and also, um, you know, sort of succumb to a lot of peer pressure in terms of eating that sort of food that, you know, his peers are eating. So not into vegetables, because my biggest fear is that, not because he doesn’t want to eat vegetables, other people are not eating vegetables, vegetables aren’t cool or something. I hope that, you know, that we will build enough of a solid foundation by the time he goes to school that he’d be able to reject that sort of thinking.

(Amy, age 35, one child)

School lunch boxes were also seen as a challenge to their children’s future food health:

You see it’s so easy in this day and age, there is so much junk out there and it’s always easy to put junk into a lunch box. And I think parents do and um, I think the kids suffer as a result of it, um, but when he’s sat next to a kid with junk in his lunch box how he reacts, I don’t know. (Lesley, age 41, one child)

I think when they are five and whatever and at school, I think it's going to be a completely different conversation. I say how you manage that space 'cause they won't completely understand, I wouldn't imagine, why they can't have things but there's all these exciting other things they can have so in people's lunch boxes, you know what I mean? (Catherine, age 41, 2 children)

Equipping their children to make the 'right' choices was important for these mothers, whilst acknowledging both how easy it is to fall into the trap of 'junk food' owing to the availability of such products, designed for lunchboxes in particular, whilst being unsure that their children will be able to resist what is on offer by 'others'. By thinking in this way, the 'junk food' lunchbox need not actually exist to be discursively powerful. By assuming that 'other people' will not be eating vegetables, or will have 'junk' in their lunchboxes, these mothers are claiming distinction for their families and their children's tastes. None of the mothers talked of their child being influenced in any positive ways by 'other' children who had an equally healthy lunchbox or made healthier food choice options. Feeling confident that they were providing their child both with the knowledge and taste for healthy eating, future concerns focused on fear that their work would be undone by those who had not worked as hard as mothers to build such strong foundations.

The importance of fitting in and eating whatever was presented at school was an alternative discursive position. Mothers adopting this position were working class and mostly younger, under 25 years of age. For these mothers having their children at a point where they would be able to sit down and manage to eat whatever was presented was of greatest importance. These mothers wanted to equip their children with the skills required to negotiate all aspects of school, including the dining room:

I'd like to think that she'd get back to, she'd eat whatever she's, well not whatever she's given, obviously if she doesn't like something then she doesn't like something, but I'd like her to get back to the point where she was eating anything. And that she would be eating her meals, all of her meals and actually enjoying the food, um, yeah that's about it. (Stef, age 20, one child)

Part of this desire was to fit in at school but it also indicated an underlying worry that children who were 'fussy' or difficult at the time of the interview would end up hungry at school, which is a powerful cause of concern:

I'd like her to be eating properly 'cause she can't just ask can she then if she's hungry. (Judith, age 21, one child)

Judith had talked of trying to stick to set lunch times with her daughter but said she did on many days 'give in' and let her eat yoghurt which was her stand by alternative to avoid her daughter going hungry, a strategy she thought would not help her daughter in the long run.

These two discourses were very much adopted according to class positions and would suggest that the middle class mothers were more forward thinking in working hard to develop knowledge and food preferences in their young children that they then hope will equip them for future choice making and the ability to counter peer pressure. The working class mothers discourse was more focussed on enabling their children to negotiate the school dining environment with their emphasis being on strategies which would mean they ate what was provided to avoid hunger rather than concern over the quality of the food consumed. These positions, to some extent, echo those found by Gillies (2005), who studied parents'

involvement in their children's education. Gillies (2005) asserts that middle class parents invested in their child's education as a means on shoring up and passing on their privilege whereas working class parents worked hard to equip their children with the skills they require to deal with the everyday issues including instability, injustice and hardship. The middle class mothers in this study wanted to establish and pass on their version of healthy eating to establish behaviour and tastes in a form of lifestyle that would protect them against differential habits of 'others'. In relation to starting school the working class mothers' priorities echoed those found by Gillies but this did not hold true when considering the connections between diet and health in the longer term.

Mothers' views on the links between food and health are discussed more fully in Chapter 1. There was a general discourse around the importance of food to future health that was shared by most of the mothers I spoke to regardless of age, education or class, albeit articulated differently. This exchange on the importance of diet between two mothers from the hostel for young mothers reflects the views of many mothers on the importance of healthy eating:

Eve: Well it has a knock on effect on a lot of other things though
doesn't it? Zoe: yeah because if they eat crap.

Carol: So do you think it is quite important then?

Eve: Yeah.

Zoe: They will grow into slobbs if they eat crap, do you know what
I mean? They will grow up sloppy. Vegetables and fruit is brain
food as well isn't it?

Eve: Like if they eat veg you're setting them up to eat it when they
are older.

Carol: Is that important to do?

Eve: Yeah, 'cause they'll know to eat healthy and they'll be prepared for it.

Zoe: Fruit and veg is brain food isn't it? It helps so, doesn't it? I don't know what it does but it's just (Millie: clever clogs) do you know what I mean. Obviously I grew up with rubbish food.

Carol: But that's something you've actively wanted to change yourself?

Zoe: 'Cause I know how disgusting and horrible and bad it is so I won't have that now and times have changed now. Back in those days it was acceptable to be eating crap every single day, do you know what I mean and today it's not. (Zoe, age 19, one child; Eve, age 17, one child, Millie, age 17, one child)

These friends are looking to the future rather than just equipping their children to deal with the present even suggesting that their choice of foods has the potential to impact their children's intellect. Although young, these mothers talk of things being different in the past showing that becoming a mother has led them to reflect on and change their view of the importance of diet. Their age is less important than their status as a mother and they negotiate good motherhood through their awareness of, and attention to, their children's diet. The middle class mothers were more explicit in the way they claimed to set their children's eating for the future:

And it's for the rest of their lives, you've got to lay down the blue print now so that they'll have healthy habits in the future. (Claire, age 40, one child)

Using the term 'blue print' shows Catherine sees a deterministic role for mothers in setting the health futures of their children. Even those who did not state their roles as strongly there was a feeling that they were setting the scene for the future and that it was important to get the building blocks in place early to set the child up for the future, incorporating a good relationship with food. All mothers, irrespective of age or social class, were forward looking to some extent, which does not support the class differences found by other researchers (Gillies, 2005; Vincent and Ball, 2007; Lareau, 2011). Much of this work considered parental involvement in the education of their children where parents' access to social, economic and cultural capital may have a more direct impact on the ways parents feel they can influence their child's educational outcome. In these circumstances, focussing on equipping children with skills to negotiate the everyday is logical for working class parents. If mothers reject the notion that health is linked to diet they are risking their moral self as mother because the normative discourse that the two are unequivocally link is very powerful. Mothers, therefore, look to the future health of their children through privileging 'healthy' food, especially fruit and vegetables, a discourse adopted to some extent by all the mothers in this study. Furthermore, although they did not have to reveal what they fed their children, many talked at length about what their children liked and ate and most emphasised 'healthy' foods. Beyond concerns over what influence 'others' would have on their lunch time food choices at school, middle class mothers talked of a number of anxieties for the future. Most mothers only talked of the links between food and health as a future concern but a few other anxieties were raised.

Anxiety for possible futures

Whilst choking and allergies were anxieties that could cause immediate harm, a very small number of mothers mentioned them. Of greater concern was the possibility of food related future problems which were only talked of by a few mothers but caused higher levels of anxiety. Emma had suffered from an eating disorder when she was younger and was concerned to make sure her children had a healthy relationship with food:

I worry about my children eating well. I worry about my children, I think, I worry about my children having the same issues I had, I don't want them to see food as the enemy. (Emma, age 35, 3 children)

Emma had suffered from bulimia from aged thirteen to when she had her first daughter aged seventeen. Although her eating had been under control since then (over eighteen years) she talked of remaining very careful about what she ate and of keeping a careful eye on her teenage daughter's eating habits. Discourses around childhood or adolescent (in Emma's case) experiences illustrate the strong emotional links between past and current food behaviour. For those wanting to replicate past experiences, most strongly articulated by middle class mothers wanting to replicate the ideal of the family meal, this was a positive associate, however, mothers who recalled food behaviours they did not want repeated talked of these in relation to worry or anxiety. Being 'fussy' was the most commonly mentioned food behaviour pattern mothers wanted to avoid their children developing. The most extreme example was Joanne, whose partner had a very limited diet when they met. She talked of her ongoing struggle to increase his dietary repertoire, with the explicit aim

of avoiding his eating patterns being replicated by their children. Initially Joanne said she was ‘not one to worry’ about what her children ate but later in the interview, when discussing her husband’s eating, she talked of worrying:

Yeah I do, it’s a lie, I do worry, um, I do worry. I wouldn’t say I sit worrying about it all day but it does cross my mind because I just don’t want them to be like their Dad to be honest... ‘cause when he was younger he was sitting there eating Christmas, everyone’s eating Christmas dinner and he’s eating peanut butter on toast. I don’t want that to be my kid. I want them to be able to sit there and eat with everyone else. (Joanne, age 28, 2 children)

Wilk (2010) talks of the stress that a ‘picky’ eater can put on family eating situations whereby the ideal of the family meal becomes the focus of anxiety and feelings of failure. None of the mothers in this study reported having a child who they described as ‘picky’ or ‘fussy’ in a problematic sense. Some had children who were difficult to feed at some point but all talked of these issues as cyclical rather than constant. Joanne is articulating anxiety over this possible future. She remained vigilant over her children taking on the responsibility by making sure that they constantly had a varied diet as she thought this strategy would minimise the chance of them replicating their father’s eating pattern. Although she talked elsewhere about the importance of a balanced diet, the goal she articulates here is focussed on the social element of eating, emphasising the importance of being able to eat the same as everyone else, therefore, being included.

Looking to the future took on a unique perspective for one of the younger mothers I interviewed, Sam, whose partner worked away from home during the

week. She was very unsure about many issues in relation to raising her children and when asked whether she worried about her daughter's eating she talked of the future:

I do worry that, I did sit and think about it the other day and were like oh when she's older she won't ask me for dietary advice. I'd be.. um, I wouldn't have a clue, I only know what my mum's told me, really that's all. (Sam, age 22, 2 children)

Many young mothers privileged their family's advice as discussed in Chapter 4. Being able to give advice to the next generation therefore is seen as an important element of being a good mother and Sam's concerns show her awareness of the moral risk of failure as a mother. Although she values her own mother's experiential knowledge, she is not confident enough about her own knowledge to feel she could pass on anything useful to her daughter. Lack of confidence was greatest amongst the younger mothers who also felt the gaze of others more acutely. Being able to advise your children about food and health was one of many responsibilities related to food provisioning that mothers accepted. The role of mothers in family food provisioning will be explored below.

Responsibility for Food in Families: Women's role

All but one of the women in my study took the lead in everyday food decision-making and preparation. All the other mothers who lived with partners had responsibility for the majority of food work from day-to-day decision-making, to shopping and food preparation. Research in the 1980s and 1990s established that women took on the greatest burden of food work in families (Charles and Kerr, 1988; De Vault, 1991, Graham, 1993). More recent work shows that little has changed as mothers retain much of the responsibility and decision-making around food

provisioning even in households where partners are involved to some extent (Stapleton and Keenan, 2009; James et al., 2009; Wilk, 2010). Most of the mothers with partners talked of their partners being involved to some extent with the clearing up of meals and in some aspects of childcare, most often feeding and putting the children to bed. The discourse was very much around 'helping' rather than sharing responsibility for food work, with the mothers in my study taking on the responsibilities for such work, irrespective of age, social class or working status. Food work remains gendered, and becoming a mother raises the expectations that women will take on greater responsibility much in the same way that Stapleton and Keenan (2009: 48) found food work was 'perceived as part of the maternal role'.

There were some differences in the involvement of partners in household food work by social class. Those who spoke of their partners doing some of the cooking were middle class mothers, although they very much retained responsibility for day-to-day food work. A number of middle class women talked of their partners cooking at weekends or for special occasions which was seen as 'glory' cooking or cooking for display:

He is completely about the 'glory cook' in our house I would say. So if people are coming over he cooks these amazing dinners and everyone's 'oh you're so lucky he's such a good cook' and I'm like 'yeah but he doesn't ever cook in the week' and I mean that's fine that's just how it works. He's at work and I'm at home so we do that. Sometimes it would be nice to have help with the thought that goes into it. (Geraldine, age 37, 3 children)

Although Geraldine and others in her situation accepted things as they were, they talked of the drudgery of everyday meal preparation and particularly decision-making with which they would appreciate some 'help'. Talking of 'help' shows mothers acceptance of the responsibility of food production, but also points to a desire for a more balanced division of labour. The labour of planning and thought, discussed by Geraldine, is that which mothers most often described as monotonous and unappreciated and it is that which is not shared, particularly by 'glory' cooks. Mothers from lower socio-economic groups talked more about the effort required to elicit any 'help' from their partners, who were seen as inept at cooking or shopping. Exacting 'help' was seen as counterproductive as it would result in more work for them:

He can't cook. He's an absolute nightmare. If I tell him how to do something he's in and out that much. If you send him for a tin of beans, down the shop, he'll be on the phone to you saying 'but which beans'. And honestly, if I send him to the shop, I have to text him where everything is in the supermarket, he's terrible. (Joanne, age 28, 2 children)

Joanne accepted the situation, and although she thought it would be 'nice' if he could cook, she did not expect the situation would change. She also pointed to what she saw as the upside: 'I ask him to cook if I want a take away, when the kids are in bed *laughs*.' Men like Joanne's partner, arguably demonstrate inadequacy in food tasks as a strategy, knowing they will not be asked, or required, to do them in the future. None of the mothers was openly critical of the division of food work in the household, or talked of either seeking change, wanting change, or expecting any changes in the future. Nevertheless, many did talk of the dull routine of daily

cooking, particularly when they believed it was not appreciated or worse when a member of the household rejected it. This links back to the earlier discussion of the power of children, in particular, to influence mothers' feelings of satisfaction or anxiety when food was eaten or rejected. By not participating in daily food work, partners take no share in this responsibility or feel the anxiety talked of by mothers. Partners were also seen as another member of the family whose food preferences and desires had to be accommodated in some way. Additional, non-child, members of the household added to the complexity of food provisioning for many mothers.

Influence of Others: Household and Other Family Members

In providing food daily, mothers must negotiate a number of elements including; individual preferences and constraints on time and budget. Most of the women with partners talked of paying some attention to their food preferences. For some, this would involve discussing what they wanted to eat the following week and for others it was a general awareness of preferences and subsequent adaptations of meals.

For a few mothers, adapting food to suit all the family had become routine, even when they state they do not pander to their children's food preferences. Beth, a forty one year old mother of four, had three children, including two teenagers and a three year old, still living at home. This is her account of her food decision-making for the family:

Beth: Mostly, well because obviously shopping is an issue, we've got so many of us it's, what I have in the fridge is what we're having for dinner. But it's things like, *older son* won't eat any sausages, for example, that have got any bits in them, they've got to

be just pork. So he'll only eat the Richmond ones and I've given in with that so I just buy a pack of those and I spread them out in the freezer, split them up, cling film. But we all have sausage and mash say or sausage and baked potato, so I'll vary it a little bit but I'm not making..

Carol: So do the rest of you have different sausages?

Beth: Yeah, but because there are so many of us the whole pack goes between us all anyway, so it's not that big a deal. I'd have to open two packs so I don't mind bending a little bit, um, and if we were to have salmon *daughter* doesn't like it so she just wouldn't have it she'd have everything else with it and that would be the way it is really. (Beth, age 41, 4 children)

Beth dismissed the above adaptations to meals as minor, yet she talked of many meals where she would have to engage in additional work in order to accommodate different family member's preferences. As additional work becomes routine, and expected, mothers view this as another element of the work required to be a good mother. The work involved in considering preferences was one aspect of the complex food work talked of by mothers. Many mothers talked about the complexity of organisation that goes into shopping and meal planning on a daily or weekly basis. Geraldine and Hayley discuss their routine decision-making when planning weekly food provisioning:

Geraldine: Um, there's a mixture, one what the kids will eat, um, and what we'll enjoy as well because I'm cooking for me and my husband as well. What we can afford in terms of what, you know, 'cause there's a limit to how much I can spend each week on food

so I need to be able to fit into that. And also what's going on that day as to whether we might be going out somewhere for the day. If it's the weekend, or the kids might have a club or something, that would affect what we cook.

Hayley: And yeah trying to get a decent, healthy meal into them.

Carol: And you and your husband does that come into it as well?

Geraldine: Yeah it does, it has to be something that we both also enjoy. (Hayley: fish fingers and chips *laughs*) There are some nights we obviously feed them first for whatever reason, then it's quite nice that we can then have something with a bit more spice in it than we would have, but it has to be something that we'll enjoy eating as well. (Geraldine, age 37, 3 children; Hayley, age 35, 3 children)

This exchange shows how many elements these two mothers are considering when they are planning meals. They talk of taste (both for themselves and their children), time, budget and enjoyment all of which have to be incorporated into meal planning. Middle class mothers articulated great complexity in their decision-making as in the example above, those who were working class also talked of juggling preferences and budgets. A couple of the working class mothers talked of the negative influence of their partners:

Sam: He will not eat anything I cook, he thinks I, he's just as bad as he [son] is actually, um, no vegetables. I make casseroles 'no I can't eat that, that's got veg in it'. 'You haven't had a mouthful yet, you can't even taste the vegetables there is that much gravy, there's

that much meat juice you can't taste the vegetables' 'No I'm not eating it'.

Carol: So what does he do?

Sam: He'll make his own food, he's, sausage on toast, pizzas. On the weekends he gets a lot of takeaways, it's quite shocking how much he can put away actually 'cause he's not, he's not fat he's quite thin actually, he's like six foot and he's like eleven stone, um, so he's quite slim but he spent like £25 on 50% off voucher that he had for pizza hut. Puddings that he goes through. (Sam, age 22, 2 children)

Sam's partner makes her attempts at getting her children to eat healthy food more difficult. Although Sam does not talk of changing what she cooks to fit with her partner, he is a negative influence in the household and certainly does none of the family food work, catering only for himself. Sue's husband has a diet that she considers very unhealthy and consequently Sue does not want him involved in feeding their daughter:

Oh I've told him, I've, believe me if he fed her rubbish all the time I'd divorce the man 'cause that's how strongly I feel about it. I've said to him it's not going to happen, don't feed her, just don't feed her anything. (Sue, age 43, 3 children)

Sue talks further of the impact she feels his bad diet is having on his health and how she is actively trying to change that by cooking more for the whole family. These two mothers were working class and for them food held a position of power in their relationships. They both had partners who they considered unhelpful at best or

detrimental at worst, on establishing good eating habits in the household. Sue was older than her husband was, and had two much older sons, from a previous relationship. Through prior knowledge of raising children, Sue held some power in her relationship. Sam, on the other hand, was young and vulnerable, and reported having had what she described as a previously abusive relationship. She was not willing to challenge her current partner, who was the father of her daughter, and whose behaviour was abusive in a different way. For both, food became an area of dispute through which power was exerted. Power as discussed in Sam and Sue's accounts of negotiating food was absent from the accounts of middle class mothers. Negotiating family and good motherhood requires mothers to take account of everyone in the family. For some mothers taking account of family members extends to an extended family group some of whom may not reside together.

Other family members also exerted influence over the feeding of children. Some mothers, typically those who were younger and who relied more on their families for support, talked about a lack of control over feeding their children. For these mothers, family members or friends had, and continued to take, control and feed their children foods the mothers did not want:

Vicky: People have encouraged what she eats as the years have gone by because, like I say, I didn't. I also didn't like her eating crisps or anything like that, and as I've gone by my friends have snuck her things, and um, so really, I mean I was angry to be fair with my friends for doing that, because it's not only on one occasion it's been on numerous and numerous and numerous occasions that it's happened. I have been angry with my friends for that because it's not your choice what my daughter should be

eating, but obviously then that encouraged me, you know, to be more... Maybe I just have to give her these things because now she's had them, now she's had the taste for them, now you've introduced her to them.

Carol: So how do you feel about that?

Vicky: Um, kind of upset that I didn't make that decision really, um. I mean ultimately I did but, um, not in the beginning. I didn't make that decision, everyone, everyone kept giving her food. It wasn't just my friends, it was my family too, um, so I felt like everyone was giving her new things I didn't want her to have anyway. (Vicky, age 22, one child)

Vicky talked at length about being careful over what she gave her daughter, yet her friends and family undermined her agency. Like other young mothers, she spoke of the inevitability of giving foods to her daughter that she did not consider ideal. She talked of herself as taking on that responsibility as she continued on a feeding path she felt unable to alter. In order to regain some control, and through this negotiate their own version of good motherhood, these mothers talked of making small changes whether in their own dietary decisions or purchasing habits.

Having the major responsibility for cooking in a household does not necessarily afford a mother control over her child's diet. This is exemplified by Nina, who lives with her extended family for whom she does all the cooking, but who does not feel in control of what her children eat:

I'm not going to say I do [have control over what they eat] because I don't, because sometimes it can be like, when I'm out, when they

are with their aunty, they'll give them something to eat where you know when I come home I'll be yelling at her why did you or, you know, do that. I mean we try not to give them peanuts and stuff and obviously a lot of children have like allergy to it. We well, I mean *son* has tried it, he's had peanuts, he likes peanut butter on his bread sometimes, so I mean sometimes it's okay for him, but I don't really have control over what they eat. (Nina, age 23, 2 children)

Where older mothers were very precise in detailing how their children should be fed in their absence, younger mothers did not talk of taking this position. They talked either of being annoyed when they found out, like Nina, or of just saying nothing as they felt disempowered to make a difference. For some mothers, having a strong policy on feeding, for example no pudding or sweets, was something that could be challenged, most often by friends and family. Others considered it acceptable for relatives to break the rules as long as they could justify these lapses as being occasional:

I mean the family's got a big thing that I don't like him to have chocolate, so they always try and snaffle chocolate into him. But I'm not actually that bad, but I think if they think I am then they might be a bit more, you know, hesitant. I just play on it and think 'well okay I don't give him anything sweet but if you want to then that's up to you'. (Lesley, age 41, one child)

Lesley talked of not being happy with the situation, but felt there was little she could do and to justify this she then talked of balance:

If you take something out completely then they'll be obsessed by it because they can't have it. So, there needs to be a little bit of a balance given really and they give that balance so it's fine. (Lesley, age 41, one child)

The giving of sweet treats by grandparents was seen as an area of potential conflict, especially by mothers who talked of having very strict rules, particularly around the consumption of sweet foods. Younger mothers saw the 'treats' as something they could do little about. Mothers adopted one of two discursive positions, talking either of creating a balance during periods when their parents were not around, or of the minimal impact of the treats on their child's diet as a whole:

I don't like it but they only see her like once a month so it's not as bad. I just know, if I know she's going there I keep her clean for like the first couple of days *laughs* try keep her off it so then when she does go she has a load of stuff it's not as bad then. (Judith, age 21, one child)

Joanne: Well my Mum takes her to *McDonald's* every Wednesday when she stops over and I mean it's a treat for her but it's not particularly something I'd give her myself but.

Carol: And how do you feel about that?

Joanne: Well, it's her Nana isn't it, and it's a little treat for her, and I don't think. I know *McDonald's* ain't good for you but I don't think one *McDonald's* a week is going to, um, do too much damage. (Joanne, age 28, 2 children)

There was a sense of inevitability in grandparents doing what they do and that it was acceptable, due to their unique position in the family. Both of these mothers negotiate their good motherhood status by acknowledging they know the situation is not ideal but that they have thought about it. Judith goes even further by making sure her daughter is 'kept off' the perceived bad foods before seeing her grandparents and using the language 'keeping her clean' which is more commonly associated with drug use showing the strength of feeling she has towards these forbidden foods. These mothers are conflicted as they appreciate the social function of 'treating' by grandparents (many of whom are relied on for support) along with the relationship they are building with their grandchildren, yet they feel the grandparents' actions are not 'ideal' or what 'I'd give her myself'. Food in this context is social and what is considered appropriate is imbued with cultural meaning. Bava et al. (2008: 488) claim that 'food provisioning practices are thus never completely uncalculated; the basis from which they derive is embodied, taken-for-granted and often escapes conscious reflection'. They further contend that such practices are constrained by Bourdieu's notions of habitus, cultural capital and field and as such are rarely reflected upon. Where other family members are making feeding decisions in place of mothers, mothers experience this in a very conscious and reflective manner. This reflects the fact that mothers in this study talked of being conscious about the broad feeding strategies they adopted for their families, particularly their children, irrespective of whether or not they wished to follow doggedly external information and advice. Within the broad strategies, much of the mundane business of feeding children week in week out was done without much conscious thought or reflection. Those who talked of the problematic intervention of other family members in relation to feeding their children were generally younger mothers. Older mothers

tended to feel more confident in telling others, family members or friends, what their feeding rules were and were not willing to accept challenges to these rules. Issues of confidence were important in how mothers felt about feeding their children and will be explored further.

Confidence in Feeding Children

As discussed in Chapter 4, knowledge about what to feed children, and affirmation that they were doing so, was mediated through ‘experts’. All mothers wanted to demonstrate that they understood both the importance of feeding children ‘well’, in terms of current and future health, along with demonstrating their own knowledge of ‘healthy eating’. Mothers talked in detail about both their successes and failures in getting their children to eat. For some it was overcoming a reluctance to eat, whilst for others, encouraging their children to eat the ‘right’ foods was the biggest challenge. Common to all these stories was the transient nature of feeding, whereby mothers talked in quick succession about their triumphs and failures. It also became clear that many of their struggles centred on early feeding experiences. Mothers in this study had at least one child aged between one and four years, which is important as they talked of developing confidence in mothering in general, and feeding their children in particular. Confidence grew as their children developed and they felt more at ease with their role as mother. Confidence as a concept was considered in different ways.

The young mothers described feelings of confidence as coming from the realisation that instinctively they know what to do:

Yeah, you just have instincts. At first, before I was feeding her I was: ‘what on earth am I going to do with her?’ just when I was

starting to wean her off and I was like ‘what on earth am I going to do with her?’ Literally, I just so didn’t know and then it just clicked to me, well what’s in them pots that you buy at TESCOs, what’s in them pots? It’s like mushed up veggies. So I just started making, I used to make her homemade cauliflower cheese and freeze it. She loved it. (Zoe, age 19, one child)

Feeling instinctual allowed mothers to privilege their own and their family’s experiential knowledge over professional knowledge. Claiming instinctual knowledge further allowed mothers to negotiate good motherhood despite their eschewing professional information and advice:

Just don’t listen to it [advice], I listen to my instincts, I don’t bother. (Nikki, age 27, 2 children)

Kids will let you know if they’re hungry or not. They are quite clever really, even when they’re babies they are clever, they know how much milk they want. If they don’t want it they’re not going to take it. You just go by your gut. That’s the way I feel about it anyway. (Polly, age 22, one child)

These mothers positioned themselves as being relaxed and confident about feeding their children, even when this had not been felt initially. Polly and Nikki were not particularly interested in what health professionals had to say and mothers who talked of instinct acknowledged their children’s agency more than those who sought out feeding information and advice. Nikki used their physicality to justify her position by saying ‘they’re happy enough and content enough so clearly there’s nothing wrong with how I’m feeding them’.

Older, middle classes mothers saw confidence as something that had developed over time. Furthermore, it had to be worked on in a constant cycle of acquiring knowledge and changing behaviour accordingly. They strove to keep up-to-date with changes and, in doing so, were able to feel confident that they knew what they were doing:

I do look online on at like BBC news and things, and obviously, there are snippets of stories, and I do research, and I do look at that research and if it was six women in Scotland over two weeks and you think right then it's not valid research. So it has to be fairly, if it's fairly steady stuff and there's good evidence then we change um, we've dropped how much meat we eat as a family, we've changed the milk we drink, we've probably changed the fruit and vegetables that we eat. (Liz, age 36, 2 children)

For these mothers, it is their innate ability to learn and adapt that is the key to feeling confident. Mothers talked of being confident at the time of the interview, but many recalled times when their confidence was low, had been undermined by particular health problems their children faced, or the way health professionals treated them. Lorna, a single mother of three, describes how her confidence has changed over the last few years:

Lorna: A lot better now, eighteen months ago an absolute state but as I say a lot better now and a lot more confident now that I just gave up on trying to push them towards the text book and just sort of left them to eat as we eat sort of thing.

Carol: So do you think you were confident with your first one and then you sort of lost confidence a bit with...

Lorna: Yeah I was confident with my first one. However, I still lived at home. I think that probably made a big difference 'cause there was always my Mum to ask at that time and then I moved out. But, as I say, I was at Uni. When I was at Uni, um, I think I fell into a convenience sort of, you know (Carol: was she at nursery then?) Yeah she was at nursery from eight until six, um, so I sort of fell into the convenience, oh quick, you know, get you this, get you that, knowing that she'd had food at nursery as well it was one of those and then of course when I was pregnant and then when we were coming to feed her [middle daughter] and she wasn't interested and we was told to wait off. It kind of knocks you back and you think oh you're doing something wrong because you know you did it right the first time and you feel you are doing it wrong because she's not eating.

Carol: So who do you think made you feel that you were doing it wrong?

Lorna: It was, because, um, I mean because we were told to wait with her and I thought 'oh okay we'll wait', you know, for a bit longer. Obviously, there was problems, or whatever, so we'll wait. But then, because we waited, and because she wasn't eating, it felt like 'okay we're obviously going wrong'. Because I knew that *oldest daughter* ate and she ate fine, so it was obviously something I thought I was doing at the time, which, you know, was not

making her and I got, like, you get over panicky about everything, you know, and everything that they had and eat and even try and so, um, it was difficult (Lorna, age 25, 3 children)

Lorna's experience with her middle daughter changed her from feeling confident to lacking in confidence and questioning what she was doing. By claiming expertise over her own daughters, Lorna regained her confidence in feeding her children.

Changing confidence was not only related to having been through, and solved, a problem. Confidence was also gained through experience, either as a single child grew or on having subsequent children. Sofia, a working mother with one child, described how her confidence grew as she became more experienced as a mother:

There'll be times when *son* has had a cold and I think 'oh you've not eaten for a week, not properly' and um I'm worried and now I've realised that's what children do when they are ill. And this might sound really daft, but I've not done this before. I can't remember what it was like when I was little but, um, you know, I just yeah, I just feel it's for me to give him the opportunities.

(Sofia, age 39, one child)

Sofia went on to describe herself as "getting the hang of it" and "getting better at it" indicating she thought there was an ideal mother against whom she is comparing herself but also indicating she was moving towards her ideal. For others, confidence developed with subsequent children. This was a powerful way for mothers to justify what they did, especially if they had gone against the 'rules' in terms of feeding.

Mary weaned her son earlier than recommended, however, she qualifies that position:

He was just hungry, constantly and, you know, he'd open his mouth and cry when you were eating and he was obviously hungry. So I just, I only gave, all he had was probably like two spoonfuls of pureed veg and baby rice at lunch time and he was fine, he wasn't having massive amounts but yeah (Mary, age unknown, 5 children)

Having had children when the guidelines (on weaning) were different gave Mary confidence to justify weaning her youngest 'early' as she had experiential evidence of no harm done. In doing so, however, Mary had to deal with the tension of recognising each of her children as individuals coupled with the expectation that what had worked previously would work again. Other mothers talked of feeling more confident with a subsequent child, through having more of an idea of what they were doing, and what to expect. This was coupled with a general feeling of being more relaxed second or third time round, and feeling less pressure to do everything 'by the book'. Mothers who talked of dealing with a difficult eating problem in a second or subsequent child, talked of feeling more confident than they would have been, had that child been their first:

I think if he'd been my first with all his problems I would probably have asked for more advice but because of having *older son* I just got on with it. (Nikki, age 27, 2 children)

Nikki had little time for health professionals and avoided any contact with her health visitors, but she felt, without prior experience, she would have needed to ask for help.

Similarly, Mary, whose fourth child suffered from extreme reflux, felt better able to cope because of her previous experience:

I always felt that I was made to feel I was doing it wrong, but then she was number four. I dread to think what it would be like if you had a reflux baby first time round 'cause you'd probably... Yeah and I thought, well she is growing, she is developing, she is meeting all of her developmental targets so actually we'll just see.
(Mary, age unknown, 5 children)

Mary relied on her prior experience to give her confidence that things would sort themselves out, despite not having had a child with this particular condition previously. Using the professional measurement milestones as evidence that she did not have to worry about her baby allowed her to negotiate good motherhood as she both rejected professional advice and accepted professional judgment of development. Mothers described their confidence as lowest during the early days of having a first baby or when faced with a new challenge in feeding their child. Choi et al. (2005) describe what they term the 'myth of motherhood' whereby mothers prior to having their first child are fed a myth that motherhood rarely meets, yet once a child is born it is hard for them to reject the myth and engage in a performance of motherhood that in itself perpetuates the myth. They go on to describe the all-consuming nature of first time motherhood arguing that mothers develop agency as they develop their skills that in turn allows them to take short cuts, particularly after a second child is born (Choi et al., 2005). This study echoes their findings, with mothers describe feelings of agency developing with subsequent children. I have equated this development with growing confidence and it reflects the confidence to negotiate motherhood on their own terms but, like the mothers in Choi et al.'s (2005)

study, none of the mothers I interviewed rejected the ideology of motherhood outright.

Conclusions

This chapter has shown that the family meal retains discursive relevance for mothers, albeit that the family meal takes many different forms. The political rhetoric that claims the family meal has lost significance in modern families and which claims this loss of relevance is the cause of many problems in families from obesity to lack of respect, is not supported by this research. Mothers all look to the symbolic role of the family meal as a demonstration of family building and commensality as was found by James et al. (2009). Family circumstances, including family composition and access to resources, further influence the ways mothers produce family eating.

Food as sociality has also been explored through which I have demonstrated the many aspects of family eating that mothers have to consider. As Coveney (2006) has argued, children since the middle of the 20th century have been taken into consideration to a far greater extent which impacts on mothers food provisioning. They not only have to take their children's preferences into consideration and provide nutritious food which conforms to government recommendations but they are also entreated to provide a meal time experience that is enjoyable and will provide them with a good relationship with food for the future.

Researchers have found classed differences in the ways that mothers consider the importance of and get involved in their children's education (Gillies, 2005; Vincent and Ball, 2007; Lareau, 2011). This body of work has found that middle class mothers are more future orientated, looking to reproduce class based privilege

in their children, while working class mothers focus on equipping their children with the skills required to deal with the challenges of daily life. I have argued that in relation to food futures mothers in this study reproduce these classed differences when considering how they want to prepare their children for starting school. Middle class mothers saw the importance of preparing their children to resist the temptation of unhealthy foods whilst working class mothers wanted to prepare their children to negotiate the dining room experience thereby fitting in with their peers. The class-based differences, however, no longer held relevance once mothers talked of the links between eating and future health. All mothers regarded their children's diet to have importance to their future health and all saw themselves as having an important role in maximising their children's future health through establishing eating patterns in their young children. There were differences in how mothers would interpret healthy eating but that is of less relevance than the common desire they showed to the future investment in their children's health.

Such investment in time and effort highlights the ongoing gendered nature of care giving within families. I have argued that mothers accept the expectation that they have responsibility for feeding their children with little resistance. A position echoed in the work of Stapleton and Keenan (2009). Although some mothers mentioned it would be 'nice' to have additional help from their partners, none saw this as an issue to pursue, or indeed something that was likely to change in the near future. Such responsibility led some mothers to feel pressure to do the right thing and I then discussed the conflicting ways that other family members become involved in feeding children. Whilst some mothers felt able to retain control, others, notably those who felt less confident, found this more of a challenge.

In negotiating the family meal mothers had to take consideration of a myriad of factors including the important social factors involved in feeding families.

Negotiation of good motherhood is therefore achieved through mothers making choices about the importance of different factors at different times. Mothers talked about past and present successes and failures in feeding their children, all of which can change very quickly, highlighting the transient nature of family eating.

Chapter 7: Discussion

This chapter will bring together the discussion from the previous four data chapters, using my research questions to structure the presentation of my main findings. Through this I will discuss the central role feeding young children occupies in mothers' lives, both as a daily undertaking, and as a consideration for the future. I will review the role of 'experts' in mothers' lives and the way they influence (or not) mothers' actions relating to feeding their children. I will also consider issues of risk in relations to feeding children, the presentation of the self as mother and the intersection of all of these issues with class and the way that class influences feeding decisions.

I will then consider how this research fits with current literature on feeding young children within families. This will show the ways this research contributes to knowledge in this area. Areas for future research will be presented and I will highlight my key findings and contribution. I will finish by considering the implications of this research for debates around policy and practice in relation to feeding pre-school children.

Research Questions

My main research question is:

In which ways do mothers of pre-school children, use, prioritise and privilege external information and advice on feeding their children, taking account of their views on feeding, feeding activities, and maternal experience?

To answer this question I consider the following secondary research questions around which I will present my main research findings:

**I. In which ways do mothers negotiate expert discourses
on how they should feed their children?**

The constant development of new information and scientific understanding of food and the way it affects the body has led to greater uncertainty (Armstrong, 1995). Coveney (2006) argues that this has given rise to increased anxiety over what we should eat, coupled with increased reliance on ‘experts’ to inform us of the best way to safeguard our health through the food we eat. The power of experts can be understood through Foucault’s concept of technologies of government (Foucault, 1988), whereby the ‘technologies of power’ allow experts to problematise food choice, giving rise to ideal diets against which individuals can be judged (Coveney, 2006). Mothers then use ‘technologies of the self’ to develop individual ethics and moral imperatives, including self-regulation (influenced by culture, society, social groups). Individuals use these ethical formations to know and act on themselves, and in case of mothers for their children. Coveney further contends that it is through expert definitions of what we should be doing that individuals derive pleasure and fulfilment when they are compliant, yet suffer feelings of guilt when they give into temptation and experience weakness leading to what he calls the ‘anxiety of eating’ (Coveney, 2006:9).

I have demonstrated that mothers are aware of expert discourses on how they should feed their children through information and advice garnered from a number of sources over a period of time, going back to when they were initially pregnant with their first child. Foucault sees expertise lying with professionals who

have training and who are legitimised through qualification (Foucault, 1988). The mothers in this study considered expertise, therefore expert discourses, as having a wider, less professionally defined, meaning. Experts were health professionals, Children's Centre workers (who had varying qualifications), authors of books on child rearing and family members or friends who they saw as having experiential knowledge, making them experts in their own right. It was clear through my analysis that all mothers remembered accessing some amount of information on moving their children from milk to mixed feeding, all talked of referring to some form of expert discourse and importantly none of them questioned whether there was a need for such generic information.

The analysis identified two broad discursive positions mothers adopted as ways of dealing with expert discourses on feeding their children. The first were mothers who were active seekers of information and advice. They negotiated expert advice by using their own experience and independent knowledge, gained through extensive reading of generic materials on child rearing and researching particular issues as they arose, including feeding, as a filter through which expert discourses could be viewed. In this way, they were able to accept official expertise on feeding their children, where it coincided with their own knowledge, and were able to reject discourses they did not agree with. Mothers who were active information seekers further realised the importance of currency of nutrition information along with the scientific relevance. They privileged government information and advice that was scientifically robust. Perceiving scientific knowledge as continually developing left these mothers feeling that their role in keeping abreast of new information and advice would not end soon. Their role in the family was to keep up with such changes whilst interpreting them and incorporating (or not) into family feeding

routines, all the while using their experience as a mediator. Mothers in this discursive position used technologies of the self to self reflect and justify their actions by establishing a moral self.

In the second discursive position, mothers privileged family information and advice over all other sources. These women were younger mothers who felt the gaze of others to be particularly harsh. They were aware of the rhetoric in which young mothers (particularly teenagers) are constructed as a moral threat, feckless, immature and largely ignorant (Macvarish, 2010). Importantly, this construction of the teenage parent assumes they will be incapable of raising a child that is not socially and biologically vulnerable (Macvarish, 2010). Gillies (2005) links this thinking to the greater individualising of family policy which constructs working class parents (not just the young) as lacking in the essential skills to raise their children. She goes on to suggest the proliferation of parenting classes is a response to 'equip working class parents with the skills to raise middle class children' (Gillies, 2005:838). Young mothers in this study sought support from other young mothers and family members who they thought would better understand them. Expert discourse as defined by Foucault held less validity for these mothers and they were able to ignore or dismiss it by privileging family who had learned through experience and not through professional qualification. It was clear that these mothers wanted to presented themselves as active decision-makers, aware of official guidelines but felt the practical advice of family members had more salience to them.

There were times when all mothers mentioned they needed particular information on an aspect of feeding their children. Older mothers, who as outlined above, were active information seekers would look to preferred websites, which

they had used before, and those most often mentioned were NHS direct, food standards agency and *Mumsnet*. Younger mothers talked of using the internet for all manner of information seeking and most used *Google* as a starting point. All of the women in this study had internet access through at least one device and often through a number, using it for instant access to information.

Older mothers engaged with expert discourses on how to feed their children also looking to experts to keep up with changing advice and advances in nutrition science. Younger mothers counter the knowledge claims of ‘experts’ talking of the validity of the experiential expertise of family and friends. Through this, they were able to use technologies of the self to negotiate good motherhood although the expertise they referred to was different to that written about by Foucault.

This research shows that all mothers are aware of expert discourses, in the traditional Foucauldian sense, on how to feed their children but they are engaged with it in a variety of ways. I have demonstrated that older mothers, most of whom were middle class, were most likely to talk of engaging directly with these traditional expert discourses whilst younger mothers dismissed them for alternative expertise in the form of family and friends.

II. How is the power of the expert experienced by mothers and how is that negotiated?

In Foucault’s understanding of the governing of populations, power and knowledge are inextricably linked. Technologies of power, primarily through the use of surveillance, are used to direct the conduct of others, which in the case of feeding children is the conduct of mothers (Foucault, 1988, Coveney, 1998). Experts retain

importance through their imparting of knowledge to guide individuals to act appropriately (Rose and Miller, 1992).

Power is experienced by mothers through monitoring, particularly during their baby's first year, through which developmental milestones and growth is measured and judged against normative charts. The ultimate power of expert exists through their ability to take action on behalf of a child, who is constructed as being innocent and vulnerable. The final sanction of the state, through the action of experts, is the power to take a child into care. Mothers in this study all talked of taking their baby to the health professionals to have their weight charted, regularly during their first year then less frequently, and all knew how their child 'tracked' against these normative scores. Although this activity is not required, knowing that your child is conforming to normal growth and development markers is considered integral to being a good mother.

Older mothers, who were active information seekers, talked of feeding strategies which were based on well informed and actively sought knowledge. Having emphasised the amount of thought that was expended on setting up these feeding strategies, mothers experienced any question of their validity as extremely challenging. These findings show that power resided with the health professionals as expert owing to mothers' engagement with the expert feeding discourse. In response, mothers referred back to their own knowledge and learned 'expertise' to construct a version of themselves as good mother. Furthermore, they responded by avoiding health professionals (most often health visitors) in the future, thus avoiding potential challenges to their status as good mother.

Some mothers described times when they sought specific help from experts but expressed particular frustration when their expertise relating to their individual children was not listened to. When this occurred power remained with the 'expert', despite mothers' feeling they had particular expertise regarding their own child. This is an important finding for health professionals who wish to engage with mothers. Ignoring their experiential knowledge in relation to specific children means working in partnership with mothers is lost. Ignoring the advice of experts was not done easily and the mothers who did so worked hard to justify their reasons by demonstrating the amount of additional research they had done, including talking to people with similar experiences. Through using this work to make informed decisions these mothers wanted to demonstrate that by questioning the 'expert' they had done more work rather than less.

A further finding of my research shows that power, associated with specialist knowledge was experienced differently. Mothers who had been referred to specialists, either paediatricians or consultants in a particular specialism, talked of these specialists's expertise in a different way. This was true of almost all mothers, regardless of their age or class. Health visitors, and to some extent general practitioners, were regarded as generalists who know about 'average' or 'text book' children, and mothers felt they could be challenged on the basis of their own expertise regarding their particular children. This rebalanced the power relationship between these professionals and the mothers in this research study. Specialists, however, were seen on a different hierarchical level and subsequently mothers found it more difficult to challenge their knowledge. Mothers in this study were only referred to a specialist if their child had a problem that their health visitor or general practitioner could not resolve. As children's problems were generally resolved

through the specialist, this could be one reason for their expertise not being challenged. Having negotiated their way through the system the specialist often presented the solution, which afforded them additional power, gratefully received. It was also the case that specialists were seen for very specific problems rather than other professionals who were consulted for more nebulous issues including ‘fussy’ eating. There was only one mother who questioned the specialist to whom she was referred. Nina’s (age 23, 2 children) son was not putting on as much weight as expected therefore she was referred to a consultant paediatrician. He monitored Nina’s son and she visited on two occasions but the specialist felt her son was healthy and made no intervention, neither did he give her special foods, both of which she had been expecting. Nina decided not to visit again as she could not see the value in the journey if it resulted in no action. These findings show that power is felt in a hierarchical way and irrespective of mothers’ age or social position all made distinctions between different experts and their ability to exert power. The more specialised an expert becomes the more power they can exert as their knowledge is seen to be further removed from that of the mother. This finding supports Giddens (1991) assertion that in our modern society increased specialisation inevitably leaves more lay people dependent on experts for knowledge, as discussed fully in Chapter 4.

Some mothers retained power by actively deciding on the amount of contact they had with health professionals. Mothers who disagreed with experts or who felt challenged by them, often chose to avoid further contact. The Healthy Child Programme ⁷ is set up to deliver regular checks on child development. After the first

⁷The Healthy Child Programme is set out by the Department of Health and outlines the dates for developmental checks and vaccinations. Details are on the NHS website.
<http://www.nhs.uk/Conditions/pregnancy-and-baby/pages/routine-checks-vaccinations.aspx>

year of life, children are offered a check around two years then are monitored when they enter school (usually by the school health team). Parents can opt not to attend the two year check and, unless the health team have particular concerns, are not often chased for an appointment. Whilst concerns over their children's weight was not a dominant discourse amongst the mothers I spoke to, two spoke of encounters with health visitors who deemed their children to be overweight. Both mothers responded by not attending further appointments and they 'ignored' subsequent phone calls or 'avoided' the health visitors. In talking about the decision to avoid the experts, one mother, Claire (age 40, 1 child), justified it by referring to her family's high levels of physical activity and the healthiness of their diet. She also referred directly to issues of surveillance and normality in growth by pointing out that her daughter was on the highest percentile for her height and weight, a fact that the health 'expert' had failed to recognise. The other mother, Lynne (age 39, 2 children), experienced the challenge in a very personal and emotional way. She too spoke of the healthiness of her daughter's diet and dismissed the action suggested by the health 'expert' (not giving her daughter biscuits) as ludicrous. Lynne used comparison to 'others' as evidence of her good mothering and the experiential knowledge of family members who reassured her of her daughter's normality, claiming that it was a stage she was going through. These findings echo those of other researchers who found parents both underestimate their child's weight and judge their children's health and weight on the basis of wider criteria than weight alone (Booth et al., 2009; Campbell et al., 2006; Jones et al., 2011; Towns and D'Auria, 2009). Mothers, like the two in this study, feel responsible for their child's weight status (Pagannini et al., 2007; Maher et al., 2010). Maher et al., (2010) found the dominant discourse around overweight children that stereotypes them as eating junk and fast food whilst watching

television, further alienates their parents. Both mothers but Lynne in particular were aware of the stereotype into which their daughters did not fit which helped them dismiss the judgement of their children as overweight. Mothers therefore disengage with health professionals who they see as judgemental. Both of the mothers in this study avoided the health professionals after only one encounter in which their child was judged overweight. Clearly, health professionals need to be aware of the power they exert in relation to this sensitive issue and approach the topic with more sensitivity.

I interviewed a number of young mothers who were living in a hostel and who experienced the power of 'experts' in a very different way. The hostel staff, who worked with health professionals in supporting the young women, held the balance of power. They assessed the young mothers' readiness for being re-housed to independent accommodation, away from the hostel, which was the goal of all the residents. For these mothers, the power of the expert could not be challenged, so they talked instead of the importance of being seen to be doing the 'right thing'. These women saw this as a necessary game they had to play and understood the consequences of not doing what was expected of them, for example making their own baby food rather than buying convenience foods. These mothers did not dismiss the dominant discourse that health and diet are connected and indeed all presented themselves as mothers for whom this was important. They negotiated the power of the expert by conforming in the short term in the knowledge that by so doing they would be considered ready to move to independent living.

As health is deemed more controllable, individuals must take personal responsibility for following the advice of experts to minimise risk to their health, whilst mothers are held accountable for their children's health (Wolf, 2011). My

research has shown that the mothers I talked with accept the dominant discourse that food and health are linked, furthermore they feel responsible for their children's eating habits. Although expertise did not reside solely with those who had professional legitimacy and expertise was situationally dependent, most of the mothers in this study referred to at least one health professional as a trusted source of information and advice. Trust was key to decision-making on whose advice to follow. In line with research by Russell and Drennan (2007) the majority of mothers in this study trusted health professionals but understanding where this trust derived from is important, as it is not necessarily easily won. Personal relationships were the most important factor in building trust, especially with younger mothers. The two most important elements of trust building were feeling listened to and treating each child as an individual. Health professionals must acknowledge mothers' expertise on their own child if they are going to build a trusting relationship with mothers.

The power of the expert is felt through technologies of government, including surveillance. Henderson et al. (2010) argue that the power of social control is no longer exerted through social institutions, rather it is felt through the constant surveillance of mothers, of each other and of themselves. Foucault too regarded surveillance as constant, however, the mothers in this study reported the episodic and temporal nature of surveillance. They reported periods they described as 'relative calm', characterised by their children eating well, according to their own version of healthy eating, and during which time they did not think much about what they were feeding their children. These periods were interspersed with periods of challenge, during which their children would not eat, were not growing as they should (according to normative charts), or were refusing food for the first time. Mothers described these times as challenging to them as mothers, and they would look to

what ‘others’ were doing to gauge their own situation. Unlike Henderson et al. (2010) the self-surveillance, along with outside surveillance from experts, was not felt constantly and often was little thought of at all.

III. In what ways do mothers negotiate, deploy and resist the discourse of good parenting (motherhood)?

In their book, Douglas and Michaels describe the discourse of good mothering; ‘with intensive mothering, everyone watches us, we watch ourselves watching ourselves. Motherhood has become a psychological police state’ (Douglas and Michaels, 2004:6). Whilst this view of the discourse of good motherhood is rather extreme, all the mothers in this study worked hard to present their actions as caring and themselves as good mothers. As outlined above, however, they do not feel this as a constant presence as described by Douglas and Michaels (2004). Mothers did look to ‘others’ to benchmark what they were doing both as a way of distinguishing what they were doing and as a way of reassuring themselves that what they were doing fitted into the discourse of good mothering. Mothers in this study talked of reassurance coming from belonging to a support network of like-minded mothers; ‘most of my friends think the same way that I do’ (Beth, age 41, 4 children). Believing such support group are ‘like-minded’ can also leave mothers very vulnerable to challenges from their peers, as was seen with Liz (age 36, 2 children) when she offered her daughter a chip, discussed in Chapter 4. For the older mothers the gaze of friends was felt more powerfully than that of professionals whose expertise they challenged through their own research and knowledge. When mothers relied on a particular individual, for example their mother, criticism of their parenting strategies, from that individual, was also very powerful, as was seen with Sam (age 22, 2 children) discussed in Chapter 4. Part of the discourse of good

mothering, relating to this study, was feeding your child(ren) according to recommendations. Another group who could challenge mothers' sense of good parenting were grandparents. Mothers of all ages talked of being challenged by grandparents at various times but there were real differences in how these challenges were negotiated. Younger mothers recognised the social element of grandparents 'treating' their children, and considered it was part of the role of grandparents and an inevitable part of being a child. They negotiated their continued position of 'good mother' by detailing how rarely their children saw their grandparents, the balance of the 'treat' amongst the whole diet, or by describing the lengths they went to reduce exposure to 'treat' food before a planned visit to grandparents to provide 'balance'. Older mothers took a more rigid stance, regarding the imposition of rules about food as more important than the social element of feeding at this stage. Older mothers were clear that they would avoid visiting any family member who was not willing to abide by their rules.

Part of the discourse of good motherhood includes good nutrition. All mothers in this study talked of the importance of balanced eating as the ideal of good nutrition whereby fresh foods were in balance with other foods, especially processed foods, convenience foods or sweet treats and snacks. In positioning themselves as good mothers, all emphasised the provision of fresh, unprocessed foods, cooked from scratch where possible, a standard that they hold up even when that ideal cannot be met all the time. Moisio et al. (2004) described the symbolic power of homemade food across different age groups, describing its importance to the ideal of family life. They suggest home-cooked food has significant moral meaning, which unequally affects women who have to struggle to realise the ideal whilst dealing with the constraining factors (Moisio et al., 2004). My own research

supports these findings as all mothers in this study identify with the home made standard, but the negotiation of this ideal differed by class. Middle class mothers talked at length of the time and effort they would put into preparing foods from scratch, and that this was an ideal they would work hard to preserve. Working class mothers held the same ideal but were more pragmatic, talking of using convenience foods when they saw it necessary. The provision of sweet treats was one area of food provision that was dealt with very differently by mothers from different classes. Middle class mothers talked of a willingness to impose strict rules on feeding in general and especially over sweet treats. Working class mothers were more likely to regard sweet treats almost as a right of childhood and certainly something they had little control over, even when this challenged their discourse of good mothering. Some of the young, working class, mothers talked of seeing themselves as 'judged' by others. Most felt challenged by this and resisted this criticism by reaffirming what they did that would afford them status as a good mother. Two of the young mothers challenged anyone's right to judge them, claiming their right to give their child what they wanted, if it made them happy, as affirmation of good mothering. Preparing food your child enjoys is an affirmation of good mothering, which is met with pride, and happiness, the meaning of which goes beyond the food itself. A large part of the mothers' sense of good mothering in this study was bound up in the reactions of their children. Although mothers were talking of food in this study, this illustrates the power that children have over their mother's sense of success. When things are going badly, or children are not eating, mothers often questioned what they had been doing that could have caused this reaction. Nothing made the mothers happier than talking, with pride, about times when their children ate, with delight, the food that was given to them. This was

even more powerfully felt when the food provided had been cooked, by them, from scratch.

Maher et al. (2013) suggest that the remit of mothering has expanded to encompass not only the present but the future health of children. This means part of the discourse of good mothering obliges mothers to be forward thinking, in preparing their children for their future. Gillies' (2005), study of parenting resources and their impact on parenting strategies found middle class parents to be forward looking, through investing in their child's education, whereas working class parents were more focussed on equipping their children to deal with the everyday realities of their lives. Similar patterns are seen in this study in the ways that mothers talked of how they wanted their children to be prepared for dealing with food when they started school. Middle class parents want their children to understand what healthy eating comprises of, and to use that knowledge to resist temptations posed by 'others' who were characterised as having less desirable food preferences or lunchbox content. Working class mothers want their children to be able to eat what they are given (either at school or when visiting a friend's house), to avoid feeling hungry, and to fit in. When talking more generally about the future health of their children and its links to diet, all mothers, regardless of class were forward thinking. This finding contradicts the classed divisions found in the work by Gillies (2005) and other researchers (Vincent and Ball, 2007; Lareau, 2011).

Class distinctions were also evident when mothers talked about giving their children foods that hold particular discursive positions. *McDonald's* epitomises processed, fast food and as such was held in particular disdain by middle class parents. These mothers talked with great pride that their child had never or rarely visited *McDonald's*. To these mothers part of being a good mother is not exposing

your children to such unnecessary foods. Working class mothers resist this particular discourse based on taste by deploying the discourse of the caring mother, giving their children an experience that they knew they would enjoy. The 'chicken nugget' was another food which held a particular discursive role, signifying a mother who was not prepared to put the time and effort into preparing food for her children. Despite general agreement amongst mothers that this represented a type of food that was not 'ideal' to feed your children, working class mothers noted that they were not able to live up to this ideal and had, on occasion, little choice but to resort to such foods. Middle class mothers, on the other hand, took pride in mentioning how little, if ever, their children had been exposed to these foods, at the same time talking about how easy it is to provide healthy food without resorting to the 'chicken nugget'. A few mothers were openly very critical of 'other' mothers who regularly fed their children these foods, not only presenting themselves as 'good' mothers but these 'other' mothers as failing in their duties as mothers. This attitude reflects the current social discourse talked of by Tyler (2013) in which certain groups (the unemployed and single parents for example) are cast as feckless and abject.

Good parenting should involve both parents equally but in reality much of the responsibility, particularly around feeding, falls on women (Stapleton and Keenan, 2009). Maher et al. (2010) saw the individualising discourse of new public health working because of women's willingness to take on the responsibility of feeding their children. This finding is supported by my research which showed that mothers shouldered the major responsibility for all food work within the household with little question of their assumed responsibility. All but one mother did all the food shopping, and all did the day-to-day food work, including planning and

preparing. A number of the women talked of their partners taking on some roles, which mostly included doing the washing up after meals and feeding children. Few women actively resisted this discourse however some lamented the lack of 'help' or a desire for more 'help' from their partners. The use of the term 'help' showed their acceptance of responsibility for food work, but also indicated their desire for a more balanced division of labour. Working class mothers, in particular, talked of the effort to elicit 'help', questioned whether it was worth it, and spoke of their partners demonstrating inadequacy as a strategy to avoid being asked, or required to 'help' in the future.

IV. How do mothers negotiate feelings of risk, control and success in relation to feeding their children?

Issues of risk, individualised responsibility and neoliberal policies have been discussed throughout this thesis using the theoretical work of Beck (1992) and Giddens (1991) as a framework. I have also discussed how many of the risks in the environment and in food are unknowable without the knowledge of experts who can inform us of what we cannot see (Draper and Green, 2002; Green et al., 2003). All of this has an impact on mothers as a neoliberal risk society presumes that mothers have overall responsibility for their children as Wolf states: 'Before conception, during pregnancy and childbirth, and throughout child rearing, mothers are charged with gathering and interpreting information, monitoring bodies and behaviour, anticipating needs, and preventing danger' (Wolf, 2011:74).

Risk is experienced both as a moral judgement from peers and health professionals (Murphy, 2003), in this case by failing to feed their children according to expert guidelines, and as assessment of harm that could befall their children

should the appropriate precautions not be taken. Wolf describes the totality of these risks as the ideology of ‘total motherhood’ through which mothers are held responsible for predicting and preventing harm to their children whether it is physical, emotional or cognitive and regardless of the costs or tradeoffs such prevention would cause to others (predominantly women) (Wolf, 2011). The proliferation of experts who are required to guide mothers is evidence, Thomson et al. (2011) argue, that getting motherhood ‘right’ is not possible.

Mothers in this study talked of breaking the guidelines on what to feed your children as risky in both a moral and a physical sense. One of the most commonly talked of rules that mothers broke was waiting until the recommended six months before weaning their child. Along with the introduction of foodstuffs earlier than recommended mothers in this study conceived of the risks in relation to being seen to be doing the wrong thing, which is articulating the risk to their moral self, rather than worrying about the perceived health risks to their children. With the exception of the possibility of allergy to nuts, mothers did not talk about health risks associated with weaning their children early or introducing other foods before the recommended time. Older mothers negotiated their sense of good motherhood though worked hard to establish themselves as discerning, having weighed up the risks and carried out appropriate research to justify their actions. They mostly adhered to the guidelines to wean at six months yet they wanted to position themselves as discursively well-informed individuals, who did not follow guidelines slavishly, but did so from a position of reflection and understanding. Younger mothers also worked hard to negotiate their good motherhood through refuting any suggestion that they were feckless by citing their experiential knowledge. They talked of having been weaned early themselves, evidently to no harm, and they

talked of their unique knowledge of their child who had clearly shown the signs of needing more food.

Food scares, or risks, were not mentioned spontaneously by any of the mothers I talked to, even when we were talking of food in the media or concerns they had bringing up their children. When prompted about any food safety stories they could remember not all mothers could recall any. Those who did remember any stories most often mentioned problems with eggs and salmonella but were generally unclear as to the source of this information or a particular incident that had prompted their awareness. The one other food safety story that was mentioned was the contamination of European cucumbers with e-coli during the previous summer. A few mothers mentioned remembering hearing about it and temporarily stopping purchasing cucumbers then going back to their normal habits when nothing more was in the press. Risks from food safety were not seen as particularly important with some mothers specifically saying they did not worry because they trusted the supermarkets not to put food that was unsafe on sale.

Issues of control and success depend, to some extent, on the ways that mothers envision feeding their children. I have shown that all mothers refer to an idealised version of family eating that differs for different mothers depending on their age and class, yet all express anxiety when their version of 'ideal' is not being realised. The middle class mothers' version of ideal centred around the provision of a home-cooked meal, cooked from scratch, eaten together as a family experiencing family time. They talk of the realities, which made the ideal difficult to accomplish, including the competing priorities of afterschool enhancement activities, bed time and partners work patterns, coupled with the complexities of children's vagaries of taste and seeming inability to sit still long enough to eat a meal, let alone experience

anything approaching family time. Mothers saw it as their responsibility to keep working towards this ideal in the hope that it would be achieved in the future. During periods when the ideal seemed very distant mothers reported feeling very anxious, yet they put these additional pressures on themselves in order to construct an ethical self. Good motherhood was negotiated through acknowledging that the idea was accomplished some of the time and stood as a beacon of success when it was. As with feelings of surveillance, all mothers talked of anxiety as cyclical rather than constant. It was largely forgotten when feeding their children was in a relatively 'quiet', unchallenging, phase.

Alongside the discourse of accepting responsibility for feeding their families, this research showed that mothers spoke of taking responsibility when their children are not eating what they 'should'. Even when reassured by health professionals, mothers, particularly those who were middle class, still reported doubts that they are not doing it 'right'. Well-informed mothers who encounter problems blame themselves and look to the possibility that they have misinterpreted the information they have so carefully sought. Rather than having the luxury of being anxious about getting it 'right', young mothers talked of worrying that their children would be hungry or were not getting enough food. Although young mothers also talked of these anxieties being cyclical, they were felt more constantly than those talked of by the older mothers. The discourse around hunger focussed on children refusing to eat food, particularly their evening meal, or the possibility of their children not eating what was provided at school. None mentioned an inability to purchase sufficient food. Good motherhood was subsequently negotiated by these mothers through giving in to their children's food preferences, particularly in the evening, even when this meant going against what they prescribed as healthy eating. In small ways they

were able to regain control which was considered a pragmatic way of dealing with the issues.

Discussion

Having laid out the ways in which my research has answered the research questions above, I now look at how it contributes to debates in the literature. In particular, I will consider the role of the expert in setting out expectations for mothers' actions, relating to feeding their children, how this is negotiated, and experienced in an age of surveillance. I will then consider issues of maternal responsibility, and how these intersect with the moral risks of failing to comply with feeding guidelines. Finally, I will consider issues of class and the ways class helps understanding of mothers' experiences of, and response to, feeding their children.

Petersen and Lupton (1996) argue that modern public health discourse is firmly focussed on the individualisation of health. Such individualisation requires individuals to know and understand the risks to their health and furthermore, to take action to minimise risks, thereby becoming a good citizen by protecting their own interests along with those of the community (Petersen and Lupton, 1996). This view is further supported by the work of Hunter and his colleagues who have studied UK health policy documents since the 1990s (Hunter, 2005; Hunter et al., 2010). Their analysis concludes that there has been an increased focus on individualised responsibility, accompanied by the marketisation of health, which they argue, will lead to worsening health inequalities (Hunter, 2005; Hunter et al., 2010). If individuals are to act responsibly to protect their health, they need to know and understand the best actions to take. To understand the ways in which the individualisation of health operates within society, Foucault's concept of

governmentality is useful (Foucault, 1988). This mechanism can help explain how power is exercised through a number of authorities in order to govern populations' health (Rose and Miller, 1992). In relation to food, Coveney (2006) has looked to Foucault's concepts of technologies and in particular, the technologies of power and technologies of the self, to explain how food choice is first problematised and then controlled. Power is exerted through expert knowledge, which is then transmitted to the individual who acts upon it. The whole question of why we need experts to tell us what to eat is bound up in the increasing scientization of food and nutrition, which has grown with increased understanding of the links between nutrition and health outcomes. Evidence from this research shows that mothers accept the dominant discourse that there is a need for information on feeding children. Although some of the mothers reported paying little attention to 'official' materials, all sought external information, advice and validation of their actions. There is a body of research which has used survey data to ascertain where mothers get their information on weaning their children (Moore et al., 2012; Walker et al., 2006; Hogg and Worth, 2009; Gildea et al., 2009). These studies, like mine, show older mothers are more active in their processes of searching for materials whereas younger mothers were more likely to get information from, and listen to, their own families. Survey data, however, does not give information on how mothers interact with feeding material or how it sits alongside other sources of information and advice. Getting information is only one element in the decision-making processes, which mothers use on a daily basis. This study looks beyond where mothers get information to consider how they engage with it and in particular how they negotiate the power of the expert.

Coveney (2006) uses Foucault to account for the pleasure and anxiety associated with eating. Mechanisms of government, including dietary surveys,

survey data and child measurement programmes, allow the population to be known, and this knowledge enables individuals to monitor themselves against normative values. Coveney (2006) argues that in relation to food, power is exercised through expert knowledge, which operates by problematising food choices. This then sets up ideals of consumption against which individuals can be measured or measure themselves. Individuals are then required to give up the pleasure and enjoyment of foods they may enjoy in order to conform to dietary regulation. Although individuals may feel good when they are meeting expectations they will also feel guilt and moral failing when they do not, which Coveney (2006: 9) describes as ‘the anxiety of eating’. For mothers this is more difficult as they are accountable for not only their own dietary regimen but also that of their children. My study shows that pleasure and anxiety for mothers extends beyond what they eat and is bound closely with what their children ate a finding echoed in the work of Bramhagen et al. (2006). Mothers self worth was enhanced when their children showed pleasure in eating foods they had cooked from scratch. To display a moral self as mother they all made an effort to talk of all the ‘good’ foods that their children would eat, in particular which fruits and vegetables they liked along with those they were willing to eat.

Problematising food choice through expert discourses of normality requires mothers to be scrutinized by experts. Expertise in a Foucauldian sense requires formal legitimisation through qualifications. It was clear through mothers’ discourse that expertise was not seen as the preserve of those with formal qualifications. Many mothers talked of experiential knowledge as expertise, which could be claimed by family members, friends or mothers themselves, particularly if they had spent time researching a particular issue. Health experts were often dismissed if they challenged a mothers’ well-considered feeding strategy. Mothers in this study were therefore

able to retain a moral and ethical self by firstly, avoiding the health professionals, as experts, who challenged them, and secondly, by establishing their own expertise through which they could dismiss the expertise of the health professional. Younger mothers had a rather different notion of the 'expert' in the first place. This conception of expertise differs to that envisioned by Foucault (1988) who regarded expertise the preserve of those with professional qualifications and through them positions of authority.

Surveillance extends beyond experts to include surveillance of the self and of others. Lupton (2012) considered mothers to be under constant scrutiny in relation to many aspects of child rearing, including diet. As she observes, 'while women's panoptic gaze is firmly fixed upon their children, others are observing these mothers and making judgements' (Lupton, 2012:14). My study demonstrates that mothers talked of 'others' as a way of benchmarking what they were doing, to reassure themselves that there were 'others' doing the same, or worse, than they were. The older mothers talked more of 'others' feeding their children less healthy food than they were, evidenced from observing other people's actions at home and what they saw in other people's shopping baskets. Young mothers talked more of older mothers' gaze being on them rather than feeling the gaze of their peers. Importantly, when mothers felt they were occupying a good phase of feeding behaviour they were less aware of and felt the scrutiny of 'others' gaze far less, therefore, like the judgement of experts, felt the gaze cyclically rather than an ever present force as suggested by Lupton (2012).

The ideology of 'intensive mothering', first discussed by Sharon Hays (1996), has retained a powerful discursive presence. Vincent (2010) claims the notion of intensive mothering has led to greater gender inequality in parenting, and a

social norm that expects mothers to take on the primary caring role. Maternal responsibility is central to mothers who wish to develop a moral self and thereby present themselves as a 'good' mother (May, 2008; Miller, 2005; Madden and Chamberlain, 2010; Allen and Osgood, 2009). Establishing a moral self as mother requires action in many aspects of mothering, including feeding. Madden and Chamberlain (2010) suggest mothers are in a constant state of anxiety over dietary practice, as they acknowledge the ideal diet and draw on alternative discursive practices to legitimise their deviant everyday dietary choices. The mothers in my research did not present themselves as being in a constant state of anxiety over dietary practice; rather their anxiety was cyclical depending on how their children are eating at any given time. Although they all subscribe to the dominant discourse on healthy eating and worked hard to present themselves as 'good' mothers, most were confident in what they were feeding their children, most of the time. Mothers spoke of times when their children were not eating or were challenging to feed and at these moments, mothers drew on alternative discourses to retain their self as 'good' mother. This research does, however, support the findings of those who have shown that care-giving remains gendered and that mothers, relatively unquestioningly take on the responsibility for childcare and the feeding of their children in particular (Stapleton and Keenan, 2009; James et al., 2009; Wilk, 2010).

Being a young mother holds a moral risk in itself. Allen and Osgood (2009) argue that teenage mothers are constructed as socially and morally deviant, despite young motherhood having some degree of legitimacy for working class teenagers. They argue that dominant social norms construct young motherhood as a non-ambition for middle class girls, who have invested in their education, leaving working class teenage mothers to be pathologised as ignorant, lacking in taste and

immoral. A number of the young mothers I spoke to were teenagers when they had their first child and many spoke of being made to feel deviant by health professionals or older mothers with whom they came into contact, supporting the findings of Allen and Osgood (2009). One, Maisy, aged nineteen, was from a middle class family, a part-time university student, in a stable relationship, and pregnant with her second child. She worked hard to present herself as a 'good' mother, which she did by emphasising that she was not on benefits, had planned her pregnancies, had the support of her family and was not giving up on her education, showing she clearly understood the dominant discourse that presents teenage mothers as feckless, irresponsible and ignorant. Her presentation of self echoes the work by Allen and Osgood (2009) in which they argue that young motherhood is eschewed as non-ambition for middle class girls who have invested too much in their education. Awareness of the moral discourse around young mothers Kirkman et al. (2001) and Hey and Bradford (2006) show, like the mothers in this research, that working class young mothers work to present the positive elements of their motherhood. Through emphasising their willingness to put their children first and the energy that comes with youthfulness these mothers can reclaim good motherhood (Kirkman et al., 2001; Hey and Bradford, 2006).

Class influences the construction of the moral self as a 'good' mother and can help us understand differences between mothers. Skeggs (1997) argues that for women, the label of working class is negative as working class mothers are constructed as 'other', not conforming to middle class norms that judge through the respectability of mothering practices and housewifery. Looking to the work of Bourdieu (1984) she also considers that working class women have a lack of alternatives, which would allow them to construct distance from necessity and

therefore distinction (Skeggs, 2004). Germov (2008) also looked to Bourdieu's notion of habitus, or dispositions, to explain the reproduction of class based food habits. This, he says, explains why Thai takeaway is viewed by the middle classes as better food than *McDonald's* or fish and chips (Germov, 2008). Such distinctions are clearly reproduced in this study, particularly around the classed notions of foods which are seen as appropriate (or not) for children. This was epitomized by *McDonald's* and the chicken nugget with middle class mothers talking of taking their children out to eat as important in their socialising but able to use their capital (economic and cultural) to choose to eat somewhere other than *McDonald's*.

Access to social, cultural, economic and emotional capital is required to enable parents to make real choices over parenting decisions, yet in current policy they are projected as standard (Gillies, 2005). Gillies (2005) further argues that middle-class parents invest in education to pass on privilege to their children whereas working-class parents equip their children with the skills required to deal with the social situations they are likely to encounter. In relation to the future health of their children both middle-class and working-class mothers in this study wanted to instil the principles of healthy eating, with the explicit aim of impacting on their food choices as adults. All mothers wanted to ensure their children had a taste for fruits and vegetables, which they saw as vital for future health and developing a future healthy eating regime. It could be argued that this is relatively easy to achieve as all mothers talked of the particular fruits and vegetables their children ate and enjoyed. Affecting education and educational outcomes, is arguably more difficult as it depends on much greater access to social and cultural capital, which is more difficult to influence if you are on a low income. It would be interesting to undertake further

research on these issues by investigating the areas of life about which mothers are forward looking.

Appropriate foods, taste and class distinctions give rise to differences in family food choices, which were clearly seen in this study. Middle-class mothers were more likely to set strict rules and boundaries around foods which they considered acceptable, whilst working-class mothers were more likely to be pragmatic about food, using their children's enjoyment as an alternative good mothering discourse. These positions echo distinction as theorised by Bourdieu (1984), and in part are the product of access to capital (Gillies, 2005). All the mothers in this study rated food as one of the most important things they currently think about when bringing up their children regardless of age or class. Backett-Milburn et al. (2006; 2010) studied parents and teenagers looking at issues of diet, weight and risk. Parents in poorer socio-economic circumstances saw diet as relatively low down on their list of worries (Backett-Milburn et al., 2006) whereas middle class parents saw diet as one of their priorities (Backett-Milburn et al., 2010). Backett-Milburn et al. (2010) argue that middle class parents are future orientated, using monitoring and surveillance to guide their teenagers' tastes towards a future adult diet that would confer health which can be achieved through their access to 'hierarchies of luxury and choice' (Backett-Milburn et al., 2010: 1322). Their study was focussed on families with teenage children who arguably are under less direct family control, resulting in parents having more issues about which to worry. Under these circumstances, it is not surprising that parents of teenage children who are living in poor circumstances see issues of violence, drugs and education of greater importance than food. The mothers in my study were all forward looking in relation to diet and health at the time of the study but all had pre-school children over whom

they exerted a great deal of control. Mothers in my study also all acknowledged the likely change in their control and influence as their children grew, therefore by the time they became teenagers other issues may take priority in their hierarchies of worry.

Key findings and contribution

There are three areas of contribution that I would particularly highlight, leading from the discussion of my research findings and in relation to the current literature.

(1) Negotiating good motherhood is continuous and achieved through focussing on what is important in feeding children at any given time. I have demonstrated that presenting oneself as a good mother was vital to all of the mothers in this study. Significantly, what mothers fed their children was shown to be less important than their ability to negotiate their version of good motherhood, characterised through their food-related choices. This negotiation process is both dynamic and deeply embedded in particular social contexts. As children grow, change their nutritional requirements and increase their agency, family food choices also change, adapting to new circumstances. Mothers all describe 'good' and 'bad' phases their children pass through [characterised by whether their child would eat the food presented to them at any period of time] and none were complacent that a 'good' phase will last or that they will never experience a 'bad' phase.

(2) Expertise is not the preserve of those with formal qualifications. Expertise is an important part of negotiating good motherhood. Experts help mothers make decisions on what to feed their children from milk feeding onwards. Expertise is situational and experiential, leading mothers to build up a group of 'experts' to whom they turn for information and advice, and this group changes over time.

Which 'expert' is turned to depends on the particular situation and whether specific or general advice is required. The credibility of particular experts depends on the abovementioned interplay of context and the process of negotiation. However, an important finding is that the group of experts that any individual mother may turn to will include a combination of professionals (those with professional qualifications), family members and other important peers.

(3) Mothers accept the links between food and health and all are future orientated.

All the mothers in this study, across a wide variety of contexts, accept the links between food and health to some degree. Even those who consider the current focus on food to be excessive, accept the dominant discourse of the health-giving properties of fruit and vegetables. This research finding directly contrasts the literature (including Gillies, 2005; Vincent and Ball, 2007; Lareau, 2011; and Backett-Milburn et al., 2010) which finds middle class mothers to be forward thinking in comparison to working class mothers who are characterised as equipping their children with the skills required to deal with everyday challenges. Class has a clear influence on many aspects of feeding children, for example, the distinction between 'good' and 'bad' food as discussed in Chapter 5. Differences found in this research pointed to working class mothers wanting to equip their children with skills to fit in and handle meal times when they start school compared to the middle class mothers who were more focussed on their children choosing healthy foods when faced with choice in school. In the longer term, however, all mothers were future oriented explicitly linking food preferences now with future health albeit articulated differently.

Each of these statements encompasses key aspects of this research, which are fully explored elsewhere, but they represent three main findings that impact on policy and practice and which challenge findings previously reported.

Limitations of the study

As a qualitative study, based on interviews with thirty-eight women, one limitation that is often raised is the inability to generalise from the research to the population. It is true that the sample of women interviewed is not, nor is it intended to be, representative of all women. As Bryman (2008) states, it is the quality of theoretical inference that is important in qualitative research and this is where this research can contribute to knowledge. Through looking at theories of risk, governmentality and class to understand how mothers of pre-school children understand, and act upon, information and advice on feeding their children, this research has validity beyond the ability to generalise.

Achieving a representative sample is an issue for all research and there are limitations to the representativeness of this sample. The women were recruited through two main methods. The first was a flyer, distributed to all mothers whose children attended a workplace nursery, which achieved four participants. I recruited all of the other mothers, through personally approaching them when they attended sessions in two Children's Centres and two playgroups. I attended two sessions specifically for young mothers and in these groups I invited all of the mothers to participate in the research. In the other sessions I attended, I approached groups of women to discuss my research and ask whether they would be willing to participate. This approach was opportunistic in that I talked to whoever was attending the session on the days I visited and I was not able to approach all women in any

session. The women were aware that the centre workers knew about the research, although I did not discuss the participants with them. The centre workers, in particular, acted as gatekeepers as they gave me permission to attend sessions where they thought I would meet women willing to participate. This was particularly helpful later in the research process as I had talked to fewer young mothers and the centre workers were able then to introduce me to groups that were run specifically for young mothers. I believe this method of recruiting mothers, although purposive, was not biased by those who ran the groups in the Children's Centres. I approached a number of Children's Centres and those I used to access my sample were the ones who were first to agreed to my using them for recruitment. I did choose one based on its location in an area of socio-economic deprivation, as I wanted to access more mothers who faced economic difficulties having interviewed a number of more affluent mothers. Overall, this approach allowed me to access mothers from a wide range of ages and socio-economic circumstances.

Policy and Practice implications

The importance of diet to health and the particular links between diet, health and obesity are set to remain policy targets for the foreseeable future. This research shows that mothers of pre-school children are aware of the dominant discourse that links diet to current and future health. Furthermore, despite differences in how mothers viewed future health none of the mothers rejected this discourse completely. I have highlighted that mothers generally felt confident that they knew the composition of a healthy diet, citing the inclusion of fruits and vegetables (five-a-day) and restricting sugar and fat. In relation to knowledge, there was no evidence that the mothers wanted more generalised, printed information on what comprises a healthy diet for their families. Those who sought information were happy to access

information as and when it was required and those who privileged family and friends would not look to such information should more be available. If mothers feel their knowledge is sufficient there is little point in health agencies producing further information in the traditional form. The research also found that health professionals, particularly health visitors, had not signposted mothers to web-based information, which they considered reliable. As I demonstrated many mothers use web-based sites to access information as and when they require it, particularly after the children are fully weaned into family eating. Websites already exist, for example, the *Change4Life*⁸ website and NHS Choices website⁹ yet none of the mothers in this study recalled having been given information on websites from health professionals. Many mothers were not aware of the NHS Choices website and none had accessed the *Change4Life* website. Both contain useful, factually correct and up-to-date information that would be of benefit to many mothers. Health professionals should be alerted to the potential of signposting such sites.

This research demonstrates the importance of relationship building in the process of trusting information and advice. Regardless of age or class, mothers talked of the significance of building a relationship with health professionals. For young mothers who privilege their own mothers over all others, key health professionals could also become trusted sources if they made the time to build relationships. Older and middle class mothers who prided themselves on spending time and effort researching the best way to feed their children often felt disempowered by health professionals who they saw as dismissing their efforts. For these women it was easy to avoid contact with health professionals and rely on themselves and like-minded friends to make decision on feeding their children.

⁸ <http://www.nhs.uk/change4life/Pages/change-for-life.aspx>

⁹ <http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/solid-foods-weaning.aspx>

Experiential knowledge for both young women, through their families, especially their mother, and for older women through their research, coupled with their unique knowledge and expertise on their individual children was important to all mothers. Health professionals must take account of this expertise if they are to gain the trust of mothers.

All mothers talked of feeling judged at some point, although the source of judgement differed between mothers. I have highlighted that young mothers felt judged because of their age and older mothers felt judged because of their feeding practices. Professionals must work to develop a non-judgemental style in order to build trust with mothers. This means listening to mothers' experiences and treating all mothers equally, even if they are young. Many mothers, from a wide range of ages and social circumstances, cited the unique qualities of Children's Centres as places to go for help, advice and the opportunity to meet other mothers facing similar challenges. Children's Centres are staffed by individuals from a wide range of professions and as such are seen as more approachable and less judgemental than traditional health professionals. Mothers perceived Children's Centre staff as having more time for them and being more willing to listen compared to health visitors and general practitioners, which is due in part to the differential pressures on each of these health services. Mothers talked of the proposed reduction in funding to Children's Centres, which they regarded as deeply worrying.

Finally, it is important to acknowledge the structural issues that impact on mothers' abilities to provide their children with the diet they would like. Although not a major finding of this study, all mothers talked about increases in food prices but those on low incomes found the impacts harder with mention made most of the increase in price of fruits and vegetables. Low-income mothers received healthy start

vouchers, which were welcomed but they talked of issues of using them locally and if they shopped online, rendering them of less use. Understanding the difficulties of living on low income was absent from many of the middle class mothers' discourses as they discussed the ease of providing healthy food. Furthermore, although not using the term, their discourse echoed that discussed by Tyler (2013), when she contends that the figure of the 'chav' has been constructed to vilify particular groups in society and through which citizens, who are economically disadvantaged, are cast as abject. These views mirror current media and political discourses, which malign those on low income, especially if they are on benefits and a single mother. This research shows also that young mothers are very aware of this discourse and work hard to show they do not conform to the stereotype. Health professionals and policy makers must be aware of the discourse and the ways it is reproduced in work. Health professionals need to consider mothers as individuals and policy makers must look at structural issues that make the feeding of children healthy food more difficult.

Concluding remarks

My research has considered how mothers of pre-school children negotiate ways of feeding their children, taking account of information and advice from a variety of sources. Through talking with 38 mothers, who ranged in age from 17 to 44 years and had between one and five children, I have considered sources of information and advice, the establishment of trust, the impact of surveillance, views on expertise, risk and the continued relevance of class. It is clear that mothers feel the responsibility of motherhood strongly and they do not question that they are unequally held accountable for their children's health and wellbeing. A few of the middle class mothers talked of some degree of joint decision-making and the desire

to have more 'help' from their partners, but this was related more to daily tasks than a sharing of responsibility.

My analysis shows that the feeding of children is one of the main concerns facing these mothers and one that occupies much of their time and effort. Mothers in this study felt this would change as their children grow and particularly when they go to school, as mothers felt they would have less control in general, and particularly over what they eat. Mothers who also had school-aged children talked of losing control as their children spent more time away from home and their influence. This research showed that these mothers generally had confidence in their knowledge about what to feed their children with knowledge coming from family, in the case of younger mothers, or through research, in the case of older mothers. Confidence in knowing what to do could not always be translated into action because of their children's agency. All mothers' sense of self was to some extent dependent on their child, and in relation to this study, their feeding. Furthermore, this study showed the extent to which children have a powerful impact on mothers' sense of good motherhood through their accepting or rejecting food.

All the mothers I spoke with worked hard to establish a moral and ethical self as mother, much of which was negotiated through class. The middle class mothers held to the discourse of 'doing the right thing' whereby feeding their children the rights foods allowed them to position themselves as good mothers. Whereas the working class mothers were concerned with feeding their children healthy food but were more pragmatic about breaking or bending the rules to allow foods which 'others' would frown upon as represented by the 'chicken nugget' and *McDonald's*. These mothers looked to an alternative discourse of good motherhood, that of the caring mother who wants her children to be happy, to claim an ethical self.

Mothers come into contact with experts relating to all aspects of parenting. In relation to feeding children such experts range from nutritionists at classes held in Children's Centres, through health visitors to web based specialists. Some mothers in this study consider specialists to include those who have experiential knowledge or expertise, therefore, for some the expert would include their own mother, or grandmother. This was particularly important for young mothers who privilege their own mothers as a source of information, advice and support. Ignoring this wider definition of expert and dismissing experiential knowledge will lead to a loss of opportunity to connect with mothers who may need support in feeding their children. As research has long shown food choice is highly complex (Murcott, 1995; Germov, 2008), interwoven in family dynamics (Charles and Kerr, 1988, De Vault, 1991; Probyn, 2000) and gives rise to both pleasure and anxiety (Coveney, 1996). This research shows that these issues all hold true, and that mothers negotiate daily the competing priorities demanded of them to retain their identity as a good mother. Reducing the messages of public health to those of choosing to eat more of the 'right' things, less of the 'wrong' and to move more will change nothing until policy makers understand that mothers are negotiating all the time with their families and themselves, often in difficult structural circumstances, to position themselves as good mothers.

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Appendices

Appendix I: Participant Information Sheet

The University of Warwick

Participant Information Sheet

Project title: Feeding children: making sense of information

You are invited to participate in this research study. It is important that you should understand why the research is being done and what your participation will involve before you decide about taking part. I would be grateful if you could take the time to read this information. Feel free to ask me any questions you have.

What is the purpose of the study?

I am a research student at the University of Warwick and my research aims to investigate how mothers of pre-school children use and make sense of all the information and advice they get on how best to feed their children. I am interested in all the information and advice you get from all sorts of places and people, and how you make sense of it. I will be looking at information and advice that comes from a wide range of sources including professionals, family, and the media]. I hope to finish doing the interviews by June 2012 and to have written up the research by July 2013.

Why have I been chosen to participate?

You have been invited to participate because you have one or more children aged between 1 and 4 years of age. I hope to recruit about 40 women to take part..

Do I have to take part?

Whether or not you decide to take part in this study is entirely up to you. I would be pleased if you did! But if you decide that you would like to take part and then change your mind, you can withdraw at any point, and do not need to give a reason. Also, if you decide to take part you are welcome to answer only those questions you want to, and should not feel that you have to answer anything if you don't want to.

What will happen to me if I take part?

If you decide you want to be in the study I will ask you if I can interview you about your experiences around feeding your child/children; what information and advice you have received and from where; what you think about that information and advice, and what you have done, or done differently, as a result..It doesn't matter if you can't remember, or haven't thought about it much – I am happy to hear what you have to say, just the same. I won't be making any judgements about what you

have heard or read, or about what you think, or say, or do. I am only interested in hearing about what you think and do, and why. The interview will last for around an hour depending on how much time you have available and how much you want to discuss and share. I would like to record the interview, with your permission, and then I will type it up from the tape myself, making sure that anything that could identify you is deleted or changed. I will send you a copy of the interview once it is typed up to make sure you are happy it is accurate and to give you the opportunity to remove any portions of the interview, or to make additions.

If I wish to take part, what will happen next?

If you think you would like to take part in this study you can contact me, Carol, by phone or text on *phone number* or by email on email I will answer any questions you have about the research and arrange a time to interview you. The interview can be arranged at a time and place suitable for you.

What will happen to the results of the research study?

The results of the study will be used by me in my PhD thesis. The material might also be presented at academic conferences and in academic journals. All information identifying you and your family will be removed or changed including names and where you live. All information gathered during the research will be confidential and remain anonymous, including in any academic publications from the research. I will send you a summary of the research when it is finished, and if you want them, any academic publications.

Who is organising and funding the research?

I am a student at Warwick University in the Sociology department. The department has reviewed and approved the study. I do not have any external funding for the research; I am funding it myself.

Contact for further information

[name and address]

Academic Supervisors:

[name and address]

Thank you for reading this information sheet and I hope you will be happy to take part in the study.

*Appendix II: Consent form***Consent Form****Feeding children: making sense of information**

As a researcher I confirm that I will:

1. Respect the wishes of the participant to decline to answer any questions and to withdraw from the research at any time. ☐
2. Treat the information given to me confidentially. ☐
3. To anonymise any data (removing or changing names and locations) to minimise the chance that the participant will be identifiable. ☐
4. To send a copy of the typed interview to the participant for them to check for accuracy and to delete or add information if they wish. ☐

The participant:

Please initial box

1. I confirm that I have read and understand the information sheet for the study. ☐
2. I confirm that I have had the opportunity to ask any questions I have about the study. ☐
3. I understand that my participation in the study is voluntary and that I am free to withdraw at any time, without giving reason. ☐
4. I agree to take part in the study. ☐
5. I agree to the interview being audio recorded. ☐
6. I understand that all the information and data on me/given by me will be anonymised and I agree that it (including anonymised quotes) may be used in this study and future publications. ☐

Name of participant

Date

Signature

Name of researcher

Date

Appendix III: Household Questionnaire

Household Questionnaire

I would be grateful if you could answer the following questions about yourself and your family. Remember that no-one other than me will see your answers!

1. How many children are living in your household? _____
2. What ages are they? _____
3. Are there any children living in your household part-time? How many? -

4. What ages are they? _____
5. What age are you? _____
6. Who else lives in your household? (tick all that apply)
 - ☐ Partner
 - ☐ Your parents/partner's parents – how many? _____
 - ☐ Other adults – how many? _____
7. In which of these ways does your household occupy your current accommodation? (please select one only)
 - ☐ Rent from council
 - ☐ Rent from Housing Association/Trust
 - ☐ Rent from private landlord /Other
 - ☐ Buying on a mortgage
 - ☐ Owned outright
8. Which of these activities best describes what you are doing at present? (please select one only)
 - ☐ Looking after the home
 - ☐ Employee in part-time job (under 30 hours a week)
 - ☐ Employee in full-time job (30 hours or more a week)

- ☐ Self employed, full or part-time
- ☐ On a government supported training programme (e.g. Modern Apprenticeship/Training for Work)
- ☐ Full-time education at school, college or university
- ☐ Unemployed and available for work
- ☐ Permanently sick/disabled
- ☐ Wholly retired from work
- ☐ Doing something else

9. What approximately is your household's weekly income including benefits, before tax?

- ☐ UNDER £200
- ☐ £200 but less than £400
- ☐ £400 but less than £600
- ☐ £600 but less than £800
- ☐ £800 but less than £1000
- ☐ £1000 or more
- ☐ Prefer not to say

10. Which of these qualifications do you have: (please tick all that apply)

- ☐ GCSE grade D-G or CSE grade 2-5 or Standard Grade level or Foundation Diploma
- ☐ GCSE or O level equivalent (Grade A-C) or O Grade/CSE equivalent (Grade 1) or Standard Grade Level 1 -3 or Higher Diploma
- ☐ A-Levels or Highers or Advanced Diploma or Progression Diploma ONC / National Level BTEC
- ☐ Higher education qualification below degree level
- ☐ Degree level qualification (or equivalent)
- ☐ Other qualifications (including foreign qualifications below degree level)
- ☐ No formal qualifications

Appendix IV: Interview Schedule

Interview Schedule : Making Sense of Dietary Information and Advice

Open question.....

‘What is it like feeding your children?’

Prompt: talk about what you do every day, what are your routines, what you find easy or hard.

Looking now at some of the issues raised in more detail. Let’s start by thinking about information and advice:

Where do you get information on what to feed your child(ren)[insert name of child if given]

Prompt: Can you think of any other sources? Have you ever got information from: health visitor, GP, friends, family members, neighbours, television, magazines, newspapers. [prompt with all that are not spontaneously mentioned]

Where do you get advice on what to feed your child(ren)[insert name of child if given]

Prompt: Is information and advice the same, are the sources the same and if not how do they differ?

How is that information and advice given?

Prompt: is it verbal or written down, leaflets, books etc

What do you do with that information?

Prompt: Do you keep written information? Do you make note of verbal information, do you worry if it is at odds with what you were doing already or what you have done with previous child(ren) or with what you believe about food and eating? Do you feel overwhelmed by the amount of information and advice that you receive?

Thinking about all the advice and information you have received, how much of it was given to you without you wanting it and how much did you ask for?

Prompt: Do people spontaneously give you advice and information? Do health professionals give advice and information at particular developmental point, check ups? Have there been specific times you have sought information? If so when and what sort of information or

have you sought information for the next stage that your child is moving on to?

Thinking of getting information and advice on feeding your child, which of the sources of information and advice do you trust the most? Why?

Prompt: go through each that have been mentioned, why do you trust or not each of them. Why is that (*source mentioned as most trusted*) most trusted? Are there any sources that you would automatically dismiss/distrust?

Does all the information and advice you get say the same thing? If not how do you deal with the new information or advice?

Prompt: Ask why they do what they have described? How does it make you feel about the advice and information you have been given?

Now let's talk a little about feeding children in general and some of the issues that you might find important.....

What is the most important thing for you in feeding your child(ren)?

Prompt: think about giving right foods, having good relationship with food, keeping the family atmosphere harmonious.

Does it matter what your child eats?

Prompt: Why, in what way, for whom? What would happen if they eat that way? Are there right and wrong ways of feeding children?

How confident are you about feeding your child(ren)?

Prompt: You feel confident that you are feeding them a balanced diet? How much to give them – portion sizes (For those feeding their child what their family eats) Where do they get information on what to eat or what makes a healthy diet for themselves.

Do you think you have control over what your child(ren) eat?

Prompt: How much control do you think you have, what other factors control what your child eats and in what different circumstances.

Thinking a little more now about meals in your household....

Describe a typical mealtime...

Prompt: think about different meal times, breakfast, lunch and dinner. What is different about them and are some more relaxed than others? If so why? Try and explore any anxiety and what it is over.

Do you like to use recipes?

Prompt: explain a little more why do/do not like to use them? How you feel about recipes and where they are found.

Do you like to try new things? For yourself and for your child(ren)?

Prompt: why do you like/not like to try new things. What encourages you / discourages you from doing so?

Does your child(ren) eat most things that are given to him/her?

Prompt: what sorts of things are rejected. Are all the children (where more than one) the same? If one more picky than other talk a bit more about that.

Do you often worry about what your child(ren) eat?

Prompt: What do you worry about and why?

Do you have any concerns over their weight?

Prompt: thinking both about now and in the future, overweight and underweight. How do they gauge that?

How would you like to see your child in terms of food and eating by the time they start school?

Prompt: How would you like them to be in relation to other children they would be at school with, eating the same things etc.

What sorts of things do you do to encourage your child to eat? What about trying new things?

Prompt: Give examples of things that might be done to encourage eating e.g. bribing, giving one food on the consumption of another, leading by example, eating together, explaining about healthy food and its importance. How important is it that they clean their plate? Do they think about how much they give to their children compared to adults in the family – idea of portion size.

What are the main influences over what food is prepared in your household?

Prompt: thinking about what is bought, finance, taste, other household members, waste.

Thinking a little more about other household members. In what ways are they involved in feeding your child?

Prompt: Do they do any of the shopping, cooking, clearing up, decision making on what is eaten? In what ways have they been involved since the child was born? How do you feel about their level of involvement?

How important is your child's diet compared to other things you have to think about in looking after him/her?

Prompt: What other issues in your child's life is important (health, education, safety, happiness etc?) Where does food and eating fit amongst all of these issues?

Are there any issues which are having a direct effect on your current shopping habits at the moment?

Prompt: have you noticed the price of particular foods going up? Has that any effect on what you buy? Any issues about food in the media? Health stories or stories on overweight and obesity?

Do you get or did you get healthy start vouchers?

Prompt: Explain what they are to jog memories. How do you feel about them? What did you do with them? Were you eligible but didn't collect them? If so why not?

Have you heard of Chage4Life Campaign? What about Start4Life Campaign?

Prompt: Explain what they are – show some promotional materials to jog memories. If they have heard of them: Did you use any of the information or advice? Where did you get the materials? Are you still using them? How useful did you find them? What is the general feeling about that kind of information in terms of where it is delivered and targeted at children (Change4life)?

Lastly I would like you to think more generally now.... How do you feel about the media messages around food and what people should eat?

Prompt: are they aware of messages, how do they feel about them in general and in relation to themselves and their families.

Finally how do you feel about the amount the government is involved in how we should eat?

Prompt: do you think they get it right? If not is it too much/ should the government do more? What should they do?

Is there anything else you would like to add about feeding your family?

Thank you for taking the time to participate in this interview.

Remember to get their address if haven't got so already to send transcript

Appendix V: Demographic Details of Participants

	Name	Age	number of children	age of children	Household Income £ per week	Education Attainment	Ethnicity
Participant 1	Catherine	41	2	10 months and 2.5	1000+	Degree+	White British
Participant 2	Maisy	19	1	16 months	200-400	Higher ed below degree	White British
Participant 3	Alena	44	1	3.5	1000+	Degree	White British
Participant 4	Sofia	39	1	2.5	1000+	Degree	White British
Participant 5	Sunita	30	1	23 months	200-400	Higher ed below degree	Asian British/Indian
Participant 6	Amy	33	2	4 and 2	1000+	Degree+	Chinese
Participant 7	Natasha	35	1	22 months	1000+	Degree+	White Other
Participant 8	Emma	35	3 (2 at home)	18 4 and 5 month	400-600	Higher ed below degree	White British
Participant 9	Marissa	35	1	2	200-400	Degree	White Other
Participant 10	Emily	26	2	3 and 4	Under 200	GCSE A-C	White British
Participant 11	Sue	43	3	19,18, 22 months	400-600	GCSE D-G	White British
Participant 12	Karen	39	2	5 and 1	1000+	Degree	White British
Participant 13	Sheila	39	2	5 and 2	600-800	Degree	White British
Participant 14	Alison	30s	2	5 and 3	Unknown	Unknown	White British
Participant 15	Katya	37	1	18 months	Prefer not to say	Degree	White Other
Participant 16	Beth	41	4 (3 at home)	20, 16, 13,3	1000	GCSE	White British
Participant 17	Claire	40	1	4	600-800	Degree	White British
Participant 18	Hilary	43	2	4 and 5 months	600-800	Degree	White British
Participant 19	Joanne	28	2	21/2 and 6 months	Prefer not to say	A level equivalent	White British
Participant 20	Nina	23	2	3 and 9 months	Did not know	no qualifications	Asian British/Pakistani

Participant 21	Judith 21	1	2	200-400	A level equivalent	White British
Participant 22	Lorna 25	3	6, 2 and 10 months	Under 200	Degree	Mixed White and Black
Participant 23	Hayley 35	3	7,6 and 2 years	1000	Degree	Carribean
Participant 24	Geraldine 37	3	7,5 and 3 years	400-600	Degree	White British
Participant 25	Lesley 41	1	13 months	1000	GCSE A-C	White British
Participant 26	Lynne 39	2	3 and 20 months	600-800	Degree	White British
Participant 27	Maryunknown	5	15,13,10,3,2	600-800	Higher ed below degree	White British
Participant 28	Liz 36	2	3 and 1	1000	Degree	White British
Participant 29	Nikki 27	2	8 and 3	Under 200	GCSE D-G	White British
Participant 30	Rachel 19	1	20 months	Under 200	A level/ equivalent	White British
Participant 31	Poly 22	1	5 months	prefer not to say	GCSE D-G	White British
Participant 32	Sam 22	2	3 and 2	Under 200	GCSE D-G	White British
Participant 33	Vicky 22	1	3	Under 200	A levels	White British
Participant 34	Stef 20	1	21 months	under 200	A level/ Btec	White British
Participant 35	Zoe 19	1	14 months	Under 200	Unknown	White British
Participant 36	Millie 17	1	5 months	Under 200	GCSE A-C	White British
Participant 37	Eve 17	1	11 months	Under 200	GCSE D-G	White British
Participant 38	Meg 20	1	18 months	Under 200	None	White British

Feeding Children

Making sense of information

If you are a mother with a child aged 1-4 years and could spare an hour to help me with a research project I would love you to get in touch.

My name is Carol Bryce and I am a 2nd year research student at Warwick University. I would like to talk to mothers about how they get information and advice about feeding their children and how they make sense of it all.



You can talk to me on your own or if you would like to get together with a couple of friends I can talk to you in a small group. I am happy to meet you at a time and place that is convenient for you.

My research will be useful to policy makers, health service



professionals and educators as it will help them provide advice and information that is more in line with what mothers want and need.

If you can help please get in touch. Call or text me, [name and contact details]

THANK YOU.